PHD

Improving the performance of public service organisations: building capabilities to recover and renew

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Award date:
2010

Awarding institution:
University of Bath

Improving the performance of public service organisations: building capabilities to recover and renew.

by

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A thesis submitted for the degree of Doctor of Philosophy- (PhD)

The University of Bath

School of Management

January 2010

"…there is nothing more difficult to take in hand, more perilous to conduct, or more uncertain in its success, than to take the lead in the introduction of a new order of things. Because the innovator has for enemies all those who have done well under the old conditions and lukewarm defenders in those who may do well under the new"

(Niccolò Machiavelli, 1532)

Abstract

Over the past 20 years, governments in many countries around the world have sought to implement governance mechanisms to measure and assess the performance of public service organisations. As a consequence, public service organisations, especially those considered as poorly-performing organisations, have been subjected to unprecedented pressure to improve their performance and sustain performance improvement as a continuous process. However, efforts of public managers to improve the performance of their organisations have been undertaken without "comprehensive theories and rigorous evidence on this issue" (Boyne, 2006: 366). This thesis takes up the challenge of providing robust evidence on the factors associated with the performance improvement of public organisations. We propose that the notion of organisational capabilities offers a promising way to meet this challenge. From this standpoint, this research sought to identify the organisational capabilities whose development and use explain a public service organisation's ability to improve its performance and sustain good performance in the long run.

The empirical analysis was conducted in a population of hospital trusts in England. We firstly applied longitudinal and comparative case studies method into two acute hospitals trusts: one case of a successful performance improvement and one case of less-successful performance improvement. The purpose was to examine how the development (or lack of) a set of capabilities over time accounted for the differences in the performance outcome and trajectory of the two cases. Our findings identified the following capabilities as advantageous for achieving a sustained performance: collective leadership; action-oriented culture; effective clinical-managerial relationship; supportive external context; performance/finance control capability; coordination capability of the key delivery process; sensing capability and learning capability.

We then employed quantitative method over the population of acute hospital trusts in England to explore the relationship between complementarities of capabilities and performance. The results demonstrated that only when in combination does the presence of the capabilities yield positive and significant association with performance. In other words, the presence of the whole system of the capabilities increases the trusts' performance, while partial presence of a set of capabilities is either not significantly associated with, or even detrimental to, the trusts' performance.

Dedication

To my wife Socorrinha Seabra, my son Gabriel Seabra and my daughter Alissa seabra. They paid dearly for my personal enterprise and unconditionally provided the deepest level of support. Without their permanent encouragement and support I would not have condition to begin and finish this Ph.D. enterprise.

To my father Francisco de Sales Seabra, my mother Wanda Nogueira Seabra, my sisters and my brothers. They have always encouraged and supported me in every moments of my journey. To them, I owe my intellectual and moral formation, built over ethical and humanitarian values, and which now constitute my reference of life.

Acknowledgements

I have many debts to acknowledge. First, I would like to thank my supervisor Professor Andrew M. Pettigrew, for his wise advice and valuable comments on draft chapters. I am also grateful for the personal effort he made to help me get access to case study organisations. This research would not be possible without his personal effort to support every aspect of my thesis, which went beyond any call of duty.

I cannot find a word great enough to express my gratitude to Michael Barzelay, Professor of Public Management at London School of Economics. The intellectual discussions we had throughout the time I spent in England contributed enormously to my intellectual formation. I am really grateful for his sincere friendship and unpretentious support provided throughout these years. His belief on the quality of my work has always been a source of strength that boosted my morale and kept me motivated to successfully complete this journey.

I also like to thank Professor Gwyn Bevan, from London School of Economics for his valuable comments on draft chapters.

At the School of Management of the University of Bath, immense thanks also go to Professor Russ Vince for his feedback on the draft chapters and support at the final stage of the thesis. I would also like to thank Professor Rod Green and Professor Andrew Brown, for their valuables comments and discussions about my research. Ms Chris Barnes and Ms Janet Buchan also deserve warm gratitude for the administrative support they provided to my research.

At Bath, I have also the pleasure to meet and work with good Ph.D Colleagues, in special I would like to thank the support and friendship of my Korean friend Kyung-Jin Min and his lovely family, and my friends John Huang and Sofia Christidi. Their friendship and support have definitely contributed to make this hard Ph.D enterprise more bearable. They played a special, supporting role in my last semester in UK, when my family had already returned to Brazil. I would like also to offer my gratitude to my neighbour in Bathampton and English tutor, Ms. Angela Prophet, who kindly and patiently helped to make my English accent more understandable.

I am extremely grateful for the financial support provided by the University of Bath, notably the ORS Award and the University Research Studentship. Without this financial support it would not have been possible to attend this programme.

The support of Mr. Nigel Edwards, Director of the NHS Confederation, Ms Helen Bevan, Director of the NHS Institute, and Dr. Peter Dawn, former CEO of the University Hospitals Bristol NHS Foundation Trust, during the administration of the questionnaire, was also decisive. I am thankful for all those persons I interviewed and those who generously gave their time to complete the survey questionnaires – they made this research possible. Special thanks go to the Directors and CEO of the two NHS hospital trusts used as case studies in this thesis.

I would also like to thank the people from my employing organisation in Brazil, The Controladoria-Geral da União, who contributed enormously to the development of my studies in the U.K, particularly the Executive Secretary, Mr. Luiz Navarro, the Federal Secretary of Control, Mr Valdir Agapito Teixiera, the Adjunct Federal Secretary of Control, Mr. Clerênio Rosas, the Director of Internal Management, Mr. Claudio Torquato, the Director of Audit of the Economic Area, Mr. Marcos Luiz Manzochi, and the General-Coordinator of Human Resources, Mrs. Simei Susã Spada.

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A&E	Accident and Emergency
AVE	Average Variance Extracted
BMA	British Medical Association
BPU	Hospital A Provider Unit
CEO	Chief Executive Officer
CFA	Confirmatory Factor Analysis
CHI	Commission of Health Improvement
COO	Chief Operating Officer
DHA	District Health Authority
GDP	Gross Domestic Production
GP	General Practitioner
HRM	Human Resource Management
MP	Member of Parliament
MTMM	Multi-traits Multi-methods
NAO	National Audit Office
NHS	National Health Service
NICE	National Institute for Clinical Excellence
PALS	Patient Advocacy and Liaison Service
PCG	Primary Care Groups
PCT	Primary Care Trust
PSU	Primary Sampling Unit
RCI	Reference Cost Index
SHA	Strategic Health Authority
TEG	Trust Executive Group
TOG	Trust Operational Group

Chapter 1 - Introduction

1.1 – Overview of the research topic and aims.

Governments' efforts to measure and improve the performance of public sector organisations have come into steep ascendancy over the past 20 years in many countries around the world. In Britain, for example, measuring the performance of public sector organizations has become almost an "obsession" in virtually all levels of the British government. Public agencies, hospitals, schools, universities, departments and even whole Local Authorities have been the subject of scrutiny to assess their performance in the delivery of public services. As a result, most of them have been labelled according to the results of overall assessment as "poor", "good", "three stars" and so on.

Those organisations assessed as poorly performing public organisations have been the subject of vigorous actions, either self-initiated or triggered by external pressure, aimed at stopping the decline and turning their performance around. As a result, a set of governmental initiatives has been adopted to achieve turnaround and "bring the laggards up to the service standards achieved by the leaders" (Boyne, 2006). Finding a way to achieve turnaround in "failing" public sector organisations has become one of the most striking challenges faced by contemporary governments. Nevertheless, as Boyne (2006) points out, attempts to achieve public service turnaround are being undertaken in the "absence of comprehensive theories or rigorous evidence on this issue". Those aspects of organisational context and process of public organisations which explain recovery and renewal of public organisations remain obscure. Therefore, theory and empirical findings that shed light on the determinants of recovery and renewal of public organisations can be of significant value.

The aim of this research is thus to identify the factors which explain recovery and renewal process of public service organisations. It also seeks to develop a 'theory for practice', which provides advice to managers who face the challenge of renewing and recovering the performance of an organisation.

In this research we argue that the notion of organisational capabilities, understood as the organisation's intangible assets that "enable an organisation to conceive, choose and implement strategies" (Barney, 1992:44), offers a promising way

to explain the process by which a "failing" organisation manages to recover and renew. From this standpoint, the poor performance phase of an organisation can be explained by the lack of some capabilities that enable it to identify and cope with the factors that cause the poor performance. Similarly, the recovery and renewal phase can be said to be the process by which the organisation develops and deploys the capabilities needed to improve the performance and sustain good performance in the long haul. Thus, this research is geared towards answering the following research questions: What capabilities do "failing" public sector organisations need to improve their performance? Why are those capabilities so crucial in explaining performance improvement? How can these capabilities be built and applied? And to what extent are those capabilities complementary, in the sense that the performance effect of one is increased with the presence of the others?

The object of the empirical research of this thesis is the public hospital trusts in England. These hospitals have been subject of robust performance accountability and management system since the late 90's to date. This accountability system enables us to identify and compare the evolution of the performance of similar organisations over a considerable period of time.

The empirical research was carried out in two stages, representing different research methods, namely qualitative and quantitative. At the first stage we adopt a processual approach (c.f. Pettigrew, 1997) over two cases of organisations that went through a process of recovery and renewal. This approach takes an ontological view of process as a sequence of event unfolding over time, within a context, that describes how things change (Van de Ven and Poole 2005). The purpose of processual analysis is thus to "account for and explain the what, why and how of the links between context, processes and outcomes" (Pettigrew, 1997: 340). This approach enables us to highlight not only the key capabilities that are linked to the organisational recovery and renewal of the public hospitals, but also how they were developed.

However, the time and complexity involved in a processual, in-depth case study research reduce the feasibility of its application in a large sample, thereby reducing the external validity of its findings. In order to overcome this limitation, this research goes a step further by carrying out a quantitative analysis over a national statistical basis of the link between the use of the capabilities identified in the qualitative stage and the

performance of the organisation. Apart from increasing the external validity, the quantitative analysis will also provide the statistical basis to examine and measure the complementarities between the capabilities in the explanation of the performance of the organisations, that is the extent to which the performance contribution of one element increases with an increase in the other elements (c.f. Milgrom and Roberts, 1990).

1.2 – Structure of the Thesis

This thesis is organised into eight chapters plus this introductory chapter. Chapter Two is the literature review. By drawing from the literature on recovery and renewal in both public and for-profit organisations, chapter two seeks to identify the organisational capabilities that determine performance improvement and long term performance in public sector organisations. The literature on organisational failure is also examined in order to identify the "capability gaps" that inform the decline of an organisation's performance and prevent it from responding to decline. This literature is extremely relevant because there is a general consensus in the literature that successful recovery strategies should address the causes of organisational failure. The Chapter then goes on to provide a critical analysis of the main contributions and limitations of the theoretical and empirical studies on organisational recovery and renewal. It is particularly focussed on the contextual and organisational aspects that explain the process by which an organisation develops its capability to recover its performance and sustain good performance in the long run. In other words, we are interested in identifying the determinants, *qua* capabilities, of recovery and renewal of public sector organisations.

Chapter Three sets out the research design and strategy for this research. It starts by presenting the themes and research questions for the empirical work. It goes on to present the ontological and epistemological assumptions that underpin our research design and methodology. The research strategy and design, including the methods for data collection and analysis, are detailed in this chapter. The research design included the use of both qualitative and quantitative methods. The qualitative methods consist of two detailed and longitudinal case studies: one case of a successful turnaround and one case of an organisation that took longer to embark on a successful turnaround trajectory. The quantitative method involved the analysis of the association between capabilities and performance of the hospital trusts using a national statistical basis.

Chapters Four, Five, Six and Seven deal with the case studies. Chapter Four provides an overview of the policy context surrounding the implementation of the performance management policy in the NHS and its key changes over the period of ten years since its inception in 1997. Chapter Five presents a detailed narrative of the first case study, the Hospital A. This is a case of an organisation that went through a successful turnaround trajectory over the period of 2000 to 2007. The narrative is basically divided into two parts: an overview of the situation that explains the "failing" situation; and the transformation process that culminated into a successful turnaround over the above mentioned period. Chapter Six provides the narrative of the second case, the Hospital B – a hospital trusts that took longer to embark on a successful turnaround trajectory. Finally, Chapter Seven is the cross case analysis of the two cases. The key capabilities, as well as the processes by which they are developed, that explain the outcome and trajectory of the two cases will be analysed and identified in this chapter.

In Chapter Eight we develop the quantitative analysis of the link between the capabilities identified in the previous chapter and the performance of the hospital trusts. The analysis will be carried out over a national statistical basis built from a survey administrated with executive directors and CEOs of all acute public hospitals in England. By following the recent developments of the literature on complementarities among organisational elements, in line with Milgrom and Roberts' (1995) seminal paper, this chapter also provides an analysis of the effect of the complementarities among the capabilities on the performance of the organisations. A crucial question addressed in this chapter is thus: to what extent are the capabilities complements, in the sense that the performance contribution of one capability increases with the presence of the others?

Finally, Chapter Nine is the conclusion of the thesis. It summarises the main findings of the research, in particular the key capabilities needed to recover and renew a public service organisation, and offers advice to managers on how they can be built and applied. It also provides a discussion of the main contributions and limitations of the research. It ends by suggesting future avenues for empirical research.

Chapter 2 - Literature Review

2.1 – Research on the causes of organisational failure and decline

The concept of organisational failure and decline is not a precise one. The same organisation at the same time can be considered as either a 'failing' organisation or a 'good' one by just looking at it from different perspectives. Thus, for the purpose of clarity, we start this section by providing a definition of organiational failure. What is a 'failing' organisation? At which moment can an organisation be considered as a 'failing' organisation?

Two definitions of organisational failure can be found in the literature. Some authors define organisational failure as the ultimate outcome of a decline trajectory characterised by an unsuccessful mismatch between the actions of an organisation and its environment (*e.g.* Cameron *et al*, 1987; Mellahi and Wilkinson, 2004; Sheppard and Chowdhury, 2005). This conception has been called "macro-failure" and represents the complete collapse of the organisation, or its exit from the market (Meier and Bohte, 2003). It is thus synonymous with concepts such as demise, death, mortality and bankruptcy (Mellahi and Wilkinson, 2004). Organisational failure has also been defined in terms of "micro-failure" (Meier and Bohte, 2003), that is, the difference between actual and desired performance (Cannon and Edmondson, 2005). In this sense, three possible outcomes following a consistent period of micro-failing can be identified, namely a complete demise or exit from the market (macro-failure); a turnaround (recovery of the organisation's performance); or a "permanent" state of low performance, what has been called "permanently failing organisations" (Meyer and Zucker, 1989). Since we are interested in the process of recovery, rather than on the complete collapse of the organisation, we adopt a "micro" perspective of organisational failure, by which we mean "consistent patterns of poor organisational performance for extended periods of time" (ibid).

Having clarified the term organisational failure we now proceed by reviewing the literature on this subject. Studies of the causes of organisational failure have typically revolved around the debate between "deterministic" and "voluntaristic" perspectives of failure (Mellahi and Wilkinson, 2004). The former centres the source of explanation on external factors beyond the control of the organisation and the latter

focuses on the role of internal management of organisations in informing the causes of organisational failure. However, many authors agree that these perspectives should be seen as complementary, rather than competing approaches (*e.g* Mellahi and Wilkinson, 2004). As Andrews *et al* (2006) points out, "theoretical frameworks that place too much emphasis on either external constraints or internal management present only a partial picture of organizational failure". Therefore, sound and comprehensive analysis of the causes of organisational failure should pay attention to these two broad explanations of failure. Building upon both "voluntaristic" and "deterministic" perspectives, this section seeks to identify the factors from both the organisational context and the managerial processes that explain failure and decline in public sector organisations.

2.1.1 – research on external causes of organisational failure

Public services organisations, like all kinds of organisations, are social systems open to diverse types of pressures and constraints from the external environment (Rainey, 1997). External environment can be conceived of as the conditions of the context within which an organisation is immersed. Such conditions have often been characterised in terms of technological, legal, political, economic, social, ecological and cultural aspects which influence the organisations (Rainey, 1997). Some authors contend that features of the environment within which public organisations are immersed are important determinants of their success or failure (Andrews *et al*, 2006 and Boyne and Meier, 2009). These authors maintain that public organisations that face adverse environmental condition are more likely to fail than those in a favourable context (Andrews *et al*, 2006).

Andrews *et al*'s (2006) analysis of 120 English Local Authorities reveals that causes of organisational failure are associated with variables that express the complexity and economic dimension of the environment. Regression analysis carried out by the authors shows that environments characterised by high ethnic diversity are significantly associated with failure. This is because, they argue, heterogeneity of the population makes it difficult, and probably costly, to elucidate its preferences and provide "standardized" services to satisfy its needs. As Andrews *et al* (2006) put it, "first, a greater effort is required to identify the preferences of different groups; and second, it is necessary to provide a greater variety of services in order to meet their requirements." Similarly, the result yields a strong association between economic condition,

operationalised in terms of declining population and single parent households, and failure of the local authorities. The rationale behind this association is that wealthy people are more likely to be able to engage in the "co-production" of the public services, thereby boosting their provision and quality (Andrews *et at*, 2006).

The association between the environment complexity, in terms of diversity of the population being served, with failure also received support from the empirical study carried out by Meier and Bohte (2003). By analysing the relation between performance decline and some environmental characteristics in a sample comprised of 1,000 Texas district schools, the authors show that organisational failure was significantly associated with the diversity of the environment with which the schools must deal. The diversity of environment was measured in terms of the percentage of African-American, Hispanic, and low-income students per district served by the schools. Similarly to Andrews' et al (2006) study, Meier and Bohte (2003) contend that the heterogeneity of the population increases the number of tasks and goals public organisations have to deal with, thereby increasing the degree of difficulty and the probability of failure.

The Andrews *et al* (2006) and Meier and Bohte (2003) studies show that features of environment play an important role in explaining failure in public sector organisations. Their studies suggest that public organisations are more likely to fail when they have to deal with a more heterogeneous set of problems and face adverse economic conditions. In these few empirical studies found in the literature that link environment characteristics and decline, the environment is typically depicted in terms of a few environmental dimensions, such as complexity – the diversity of external components an organisation has to deal with (Dess and Beard, 1984) - economic (e.g. poverty) and demographic condition (e.g. population size and characteristics). Few studies were found that sought to provide a more comprehensive analysis of environment, encompassing other dimensions such as the institutional and political. These dimensions would encompass aspects varying from more general values and institutions of the political economy to the role of specific actors, such as politicians, interest groups, news media and legislature, to accountability and governance systems of the government (Rainey, 1997). Jas and Skelcher's (2005) empirical study of recovery attempts in U.K. Local Authorities, for instance, suggests that the nature of local politics (e.g. highly contested and factionalised) and the relation between local political leaders with the organisations senior managers (e.g. managers with little or no

support from key political actors) can preclude "failing" local authorities from recovering their performance.

External political authorities play an important role in the performance of public service organisations (Pitt and Smith, 1981). Public service organisations are embedded in a complex network of external political actors and institutions, which either formally (e.g. by imposing policies due to their formal power and authority) or informally (e.g. exerting political pressure against strategies that runs counter the 'parochial' interest of politicians) influence their operations and performance. An analysis of the health care system in UK serves to provide a clear illustration on how the political and institutional context can impact the performance of a public service organisation.

From 2001 public heath care organisations have been subject to an externally imposed performance evaluation system, which annually measures and publishes a summary of the performance for each organisation. By 2006 this summary was operationalised in term of a single score using a 'Star Rating,' varying from "zero star" to "three stars" (the latter being the highest level of achievement). From 2006 the 'star rating' system was replaced by the "national health check", which uses a four-scale rating varying from "weak" to "excellent", and split the overall performance into two aspects: "use of resources" and "quality of services" (Healthcare Commission, 2005). Scores have been allocated according to the achievements of a series of performance indicators, which encompass a set of targets defined top-down by the Department of Health. Organisations that fail to achieve the pre-established standards are then subject to pressure and/or intervention to turn their performance around. Central elements of the government policy to improve the performance of "failing" organisations includes "franchising", *i.e*. the replacement of the CEO or/and top management team, and external support from agencies created specifically to promote performance improvement (Harvey *et al*, 2005). This creates a kind of "target-and-terror" system of governance, in which public managers of health care providers face an increased risk of being fired as result of poor performance (Bevan and Hood, 2006).

Bevan and Hood (2006) highlight a wide range of institutions involved in the performance management system of the UK National Health Service. This includes two Central Agencies, namely the Prime Minister's Delivery Unit (which monitors the achievement of targets by a "war room" approach) and the Treasure (which uses

performance targets to allocate public funds). More directly, the Department of Health finances and manages at arm's length a total of about 400 health care providers (152 primary care trusts and about 247 NHS trusts[1]). There are also 10 strategic health authorities (SHA), which are responsible for the strategic leadership, the development of the NHS' organisations and staff and the performance management of the health care providers in a geographic area of around 5 million people. This leads ministers at the Department of Health and senior managers of SHA with formal authority to impose polices and changes on health care providers.

From 2001, the performance of the health care providers, expressed in terms of "star rating" had been assessed and published by the Healthcare Commission (formerly Commission for Health Improvement). Following the publication of the ratings, "failing" organisations were required to negotiate and submit a performance improvement plan to their concerned SHAs. SHAs, in turn, become responsible for monitoring the implementation of the trusts' performance improvement plan. The Department of Health then oversees the improvement efforts and responsibilities of the SHAs (Harvey *et al*, 2005) and provide external support through the creation of organisations to promote performance improvement. By 2005 this external support had been provided by the Performance Development Team of the Modernisation Agency, created in 2001 to promote performance improvement in "zero- and one-star" organisations. In 2005, the Modernisation Agency was replaced by the NHS Institute for Innovation and Improvement. The Performance Development Team also ceased to exist and its function was transferred to a newly created Performance Support Team, that reports directly to the Department of Health (Ibid).

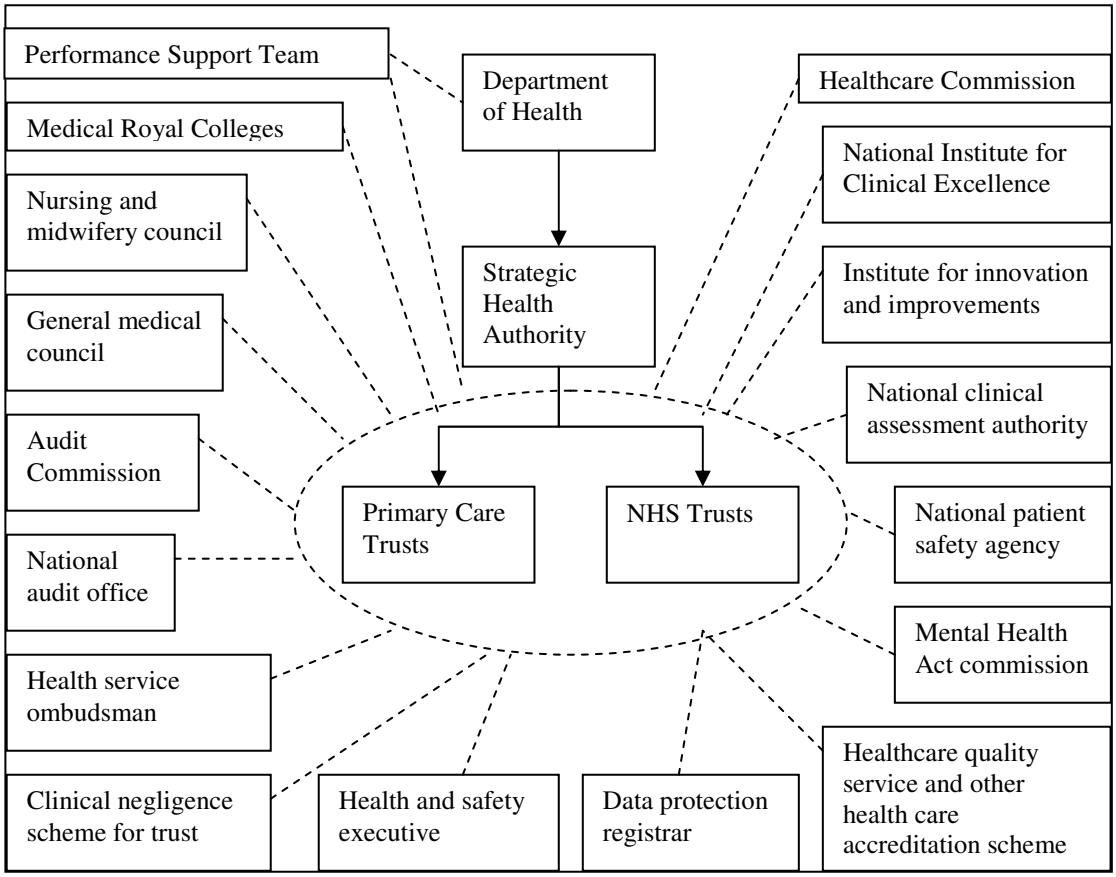
Over the past 20 years health care providers had to cope with a succession of policy initiative and waves of top-down imposed changes (McNulty and Ferlie, 2002; Walshe, 2003). The impact of this succession of changes on the performance of health care providers has been identified as an important external cause of organisational failure. An empirical study of the process of failure and recovery in nine UK hospital trusts carried out by Fulop *et al* (2004) identified the major changes in policy and NHS organisation as the main external cause of failure. The authors revealed that during these changes stakeholders "were unsupported and confused about priorities [and] managers "were unable to keep in step with the rapid pace of change which required them to

[1] Including Acute Hospital Trusts, Mental Health Trusts and Ambulance Trusts.

transform both their roles and adjust to the changed expectations of partner organisations."

Added to the direct influence of higher ties of the NHS bureaucracy over the health care providers are a wide range of agencies that regulate and/or oversee them (see diagram below), each of them demands data and makes recommendations/impositions that often conflict with the others agencies' demands (Walshe, 2003). The effect of this complex web of regulators and oversees on the performance of the health care providers can be expressed in terms of, at best, unnecessary duplication and waste of resources and, more damaging, high opportunity cost, impairment of their capacity to manage effectively and the creation of "a culture of defensive compliance, rather than one of creativity and innovation" (Ibid: 153). Fulop *et al*'s (2004) empirical study of the process of failure and turnaround in UK's hospital trust also reported that this complex regulatory framework had the effect to constrain managers' capacity to develop and direct a strategic vision to recover the performance of their organisations.

Figure 2.1 – Regulatory network of NHS Trusts



Adapted from Walshe (2003)

Notwithstanding the relevance of the diverse dimensions of an organisation's external context to influence its performance, the analysis of the impact of features of the environment on organisational performance offers a partial and incomplete view of the causes of organisational failure. Organisations can also adopt strategies and managerial processes to adapt or even change the environment (Child, 1972). Bad management, on the other hand, can prevent organisations from adapting and responding to failing situations. The literature that highlights the relationship between failure and managerial and organisational processes will be reviewed in the next section.

2.1.2. Research on the influence of organisational and managerial processes

Several researchers have mentioned the inadequacies of the organisation's characteristics and managerial processes in dealing with threats from the external environment as the main source of organisational failure (Levy, 1986; Greenhalgh, 1983 and Weitzel and Jonsson, 1989, Mellahi and Wilkinson, 2004). These inadequacies are of diverse natures, such as the managers "mental models" (e.g. Hodgkinson and Wright, 2002) and the lack of organisational processes to provide decision-makers with information on both internal and external organisational condition that have a bearing on the organisation's performance (Hambrick and Mason, 1984). This implies that organisations can adapt to the demands and needs of the environment as long as they adopt the right strategies and organisational processes that maximize their resource capacities (Andrews *et al*, 2006). Conversely, inadequate strategies and organisational processes may throw the organisation into a decline trajectory and prevent them from recovering.

Of analytical relevance in the study of organisational decline is therefore the identification of the organisational and managerial aspects that inform the organisation's inability to responding to decline. However, one problem of deriving patterns of explanation of decline from the literature stems from the fact that the empirical studies are widely dispersed and fragmented into diverse fields of study, ranging from organisational psychology to organisational studies and organisational sociology. For instance, organisational psychology has tended to explain decline by focussing on the behaviour of small groups of decision-maker (*groupthink* theory; e.g. Janis, 1972, 1982) or individuals and groups in face of threatening situation (*threat rigidity theory*, e.g. Staw *et al*, 1981). Organisation Studies scholars have focussed on the demographics of

top management team (*Upper Echelon Theory*, e.g. Hambrick and Mason, 1984). Scholars drawn from Organisational Sociology have explained organisational failure by focussing on the power and collective action of key actors (e.g. Meyer and Zucker, 1989). Hence, the explanation of the internal causes of organisational decline found in the literature reflects the idiosyncrasies of the academic discipline on which the studies are conducted.

Very few attempts have been made to provide a theoretical model that pulls together dispersed research and theories on the causes of organisational decline. Such attempts are typically found in studies that seek to model the decline trajectory into a chronological sequence of phases or stages, each with its distinctive characteristics (*e.g.* Weitzel and Jonsson, 1989; Hambrick and D'Aveni, 1988; and Adler, 1991). These models, in general, start with a stage which represents the "seeds of decline", characterised by the organisation's failure to detect change in the environment that threatens the organisation's performance (Weitzel and Jonsson, 1989). It then includes middle stages that highlight the organisational inaction and its subsequent feeble efforts to turn their performance around (Adler, 1991). The last stage is often characterised by organisational death or dissolution. Although such models might represent an oversimplification of a much complex reality, they do serve as a guide to identify some constructs to examine in the process of organisational decline.

Hence, a comprehensive account of the causes of organisational decline includes an analysis of the three main constructs taken from the model of organisational decline trajectory. These include: (i) failure to detect changes in the environment that might threaten organisational performance (Blindness); (ii) failure to decide on corrective action, despite signs of deteriorating performance (decline due to inaction); and (iii) failure to reverse the decline trajectory by either taking a wrong decision, or failing to implement corrective actions (faulty action) (Weitzel and Jonsson, 1989). These failures can throw the organisation into a severe crisis which might eventually end up as the organisation's dissolution, or macro-failure.

The three above mentioned constructs allow the raising of key questions regarding the determinants of organisational failure. In particular, what are the features of the organisational context and managerial processes that prevent organisations from anticipating or detecting changes in their environment that might threaten organisational

performance? Similarly, what are the characteristics of the organisational context and processes that prevent organisation from deciding on corrective action to respond to the signs of decline? And finally, what organisational and managerial processes inform the organisation's failure to implement the measures needed to recover its performance? In order to answer these questions we review the most relevant theoretical and empirical studies in which features of the organisational context and managerial processes appear as key to understanding each of the causes of decline mentioned above. These three broad questions place in a coherent context the hitherto dispersed literature and, taken together, provide a reasonably comprehensive, as opposed to fragmented, account of the causes of organisational decline.

2.1.2.1. – research on the causes of organisational "blindness"

In order to detect and anticipate changes in the organisational context that might affect organisational performance, organisation's managers must be able to obtain and interpret environmental information. But what are the organisational features that blind organisations to changes in their internal and external environments that might threaten future performance? This issue of management perception of characteristics of the environment has been addressed by three sets of empirical studies, namely environmental scanning (Thomas *et al*, 1993; Hatum and Pettigrew, 2006 and Daft *et al*, 1988); upper echelons or characteristic of top management team (Hambrick and Mason, 1984); and studies focussing on organisational structure (Huber *et al*, 1975; Leifer and Huber, 1977; Milliken, 1990 and Thomas and McDaniel, 1990).

Environmental and organisational scanning are features of managerial processes that enable managers to detect or anticipate changes that might threaten organisational performance (Thomas *et al*, 1993; Hatum and Pettigrew, 2006 and Weitzel and Jonsson, 1989, Hambrick, 1982). Environmental scanning is defined as "the process of monitoring the environment and providing environmental data to managers" (Daft and Weick, 1984, Hambrick, 1982). Organisational scanning involves monitoring and gathering data from the organisation's internal context to identify some aspects that might bear on future performance (Thomas *et al*, 1993, Cowan, 1983). Lack of periodic organisational scanning can prevent organisations from detecting some aspects that cause seemingly minor problems, but that, if not remedied, can later be a source of organisational failure (Weitzel and Jonnson, 1989).

Several studies have provided empirical evidence on the relation between scanning behaviour and organisational performance. In his studies of chief executives in 50 companies Daft *et al* (1988) showed that the frequency and broadness of environmental scanning carried out by chief executives was positively associated with high performance companies. Similarly, in a comparison between less and more flexible companies in Argentina, Hatum and Pettigrew (2006) demonstrated that environmental scanning behaviour was a remarkable characteristic of organisations that displayed a greater capacity to anticipate, detect and adapt to changing circumstances. In both studies, the external environmental was depicted in terms of both the operational environment (e.g. customer, supplier, competitors and technology) and the broader environment (e.g. economy, politics, social and cultural aspects and regulation). In Hatum and Pettigrew (2006) the scanning behaviour was examined in terms of both formal and informal structures for scanning. The former refers to the formally established structure in the organisation responsible for obtaining information from the environment. The latter involves informal talks, meetings and activities to discuss issues related to both operational and broader context (Hatum and Pettigrew, 2006). Their studies revealed that the lack of formal and informal environmental scanning behaviour had some negative consequences for the adaptive performance of the examined companies.

The characteristics of top management teams have also been associated with the organisational capacity to anticipate and detect environmental changes. Hambrick and Mason (1984) point out that in assessing their environment, what decision makers see and perceive is limited by their cognitive base, values and idiosyncrasies. These aspects serve to "filter and distort the decision makers' perception of what is going on and what should be done about it" (ibid). Hence, homogeneity or uniformity of the top management team can introduce bias in the environmental scanning in favour of the perspective and idiosyncrasies of the dominant function of the organisations. In contrast, the diversity or heterogeneity of the organisation's dominant coalition improve the organisation's prowess not only to "sense" the environment, but also, and perhaps more important, to make sense of the information gathered from it (Pettigrew and Whipp, 1991:117 and Hatum and Pettigrew, 2006).

Although most empirical studies have been concerned with private sector organisations, there is no reason to accept that capacity to detect change in the external

environment is less important for public sector organisations. Public organisations need to be attentive to the needs and demands of the key stakeholders, such as unions, customers, suppliers, regulators, central units (Bryson, 1995). Empirical research carried out by Bailey (2005), for example, on five further education colleges in England revealed how a new frame of reference brought about by changing the managerial team was important in making sense of environmental information that had a bearing on organisational performance.

Regarding the characteristic of organisational structure, the few empirical studies found in the literature have yielded mixed and in some cases contradictory results regarding the way structure influences environmental perception. For instance, a laboratory experiment conducted by Huber *et al* (1975) showed that perception of environmental uncertainty is more associated with groups working in a more mechanistic than organic structure (Burns and Stalker, 1961). In a similar vein, Milliken's (1991) study of top-level administrators of 122 colleges and universities yielded no significant association between perception of effect of environmental change and level of decentralisation and participation in decision making processes. In contrast, other empirical studies have shown strong association between organic structures, coupled with higher level of boundary spanning activity, with individual's perception of environmental uncertainty (*e.g* Leifer and Huber, 1977 and Thomas and McDaniel, 1990).

Even if the organisation has managerial and organisational processes that detect or anticipate changes in the environment that might affect negatively the performance, it may still fall into decline by failing to decide on corrective action to respond to the decline situation (Weitzel and Jonsson, 1989). But what prevents organisations from deciding on corrective action, despite evidence showing a deteriorating performance? Similarly, what managerial and organisational aspects influence the quality of the decision taking by managers? The next section will address these questions by reviewing the relevant literature on the causes of organisational inaction.

2.1.2.2 – research on organisational inaction

Studies examining the causes of failure in organisations have shown that evidence of declining performance does not necessarily trigger actions towards

reversing the decline in the organisation's performance (Jas and Skelcher, 2005; Turner *et al*, 2004, Weitzel and Jonsson, 1989). These studies highlight that the behaviour of managers in failing organisations has often been characterised by "denial", "avoidance", "resistance" and "procrastination" (Weitzel and Jonsson, 1989, Jas and Skelcher, 2005). Furthermore, even if an organisation decides on corrective action, it still can fail by taking a faulty decision (e.g. Smart and Vertinsky, 1977; Janis, 1972, Turner and Pratkanis, 1998). The studies of the causes of organisational inaction have typically focussed on the behavioural aspects of managers in a decline situation.

Some groups of studies have focussed on behavioural aspects of top management teams as the source of organisational inaction that prevents organisations from acting on performance information. Organisational inaction has been attributed to a state of cognitive inertia and rigidity of mindset generated from reliance on knowledge learned from past success experiences (Starbuck and Hedberg, 1977; Nystrom and Starbuck, 1984); from managers' commitment to a failing course of actions (Staw, 1981); from managers' tendency to react rigidly, either by restricting information processing or constricting control, in face of threat (Staw *et al*, 1981; D'aveni, 1989; and D'Aunno and Sutton, 1988); and from concurrence-seeking behaviour which occurs in tight and homogenous group comprised of managers in the top position of the organisation (Janis, 1972 and Turner and Pratkanis, 1998). Such a convergence prevents learning and therefore blinds managers to alternative and perhaps more correct solutions (McKiernan, 2003).

These effects of the rigidity of mindset on the decline of public sector organisations have been evidenced in the empirical studies carried by Turner *et al* (2004). Their research of the recovery attempts of 10 English Local Authorities evaluated as poorly-performing organisations reveals that the managers of 3 organisations were "deluded thinking that their past successful practices…were still current despite the presence of external information that challenged this view". This behaviour seems to support the idea that "success breeds failure" (Starbuck and Hedberg, 1977). The effect of cognitive inertia was also reflected in the managers' unwillingness to act in order to turn the performance around, or unawareness of the need for turnaround evidenced in 6 of the organisations studied. In all of these organisations, failure has been associated with a "*head-in-the-sand*" management, in

which managers believed that the standards of services delivery were still acceptable, despite performance results demonstrating the contrary (Turner *et al*, 2004).

The role of management agency in explaining why some organisations are able to respond to threatening situations was also addressed in the empirical research carried out by Webb and Pettigrew (1999). By analysing the adoption of innovation in the insurance industry these authors demonstrate that the organisation's capacity for action was an important factor in informing the difference between the pace of response between less and more agile organisations. The capacity for action was operationalised in terms of three components, namely the willingness of key individuals to questions their views of themselves and the environment (the "how" and "what" they do) the degree of bias for action and the presence of a vision of the future to guide the actions of the organisation.

Three implications stand out from the above discussion. First, management agency exerts a considerable role in explaining why some public organisations are able to recognise and decide upon corrective action in response to performance data while others remain in a "permanent" state of inertia. The absence or deficit in the capacity for action of key individuals is thus an important determinant of the organisational inaction in the face of threat or adverse performance data. Second, the homogeneity of the dominant coalition contributes to increase the rigidity of mindset and narrows the knowledge base of the organisation deemed necessary not only to recognise the need for change, but also to identify potential alternatives to respond to failing situations (Smart and Vertinsky, 1977). Third, the effects of decline on decision-processing notably in terms of centralisation and reduced participation limit the cognitive capacity of the organisation and its ability for creative solution (ibid.).

In summary, research that focuses on the behavioural characteristics of managers in declining situations suggests a deficit in the capacity for action and rigidity of mindset of the dominant coalition as one of the main causes of inaction or faulty decision. It also highlights that a non-participative and centralised decision-making process displayed by organisations in situations of decline affects negatively their cognitive ability and, as consequence, the quality of the decisions needed to recover the performance.

2.1.2.3 – research on the causes of faulty implementation

Although having the "correct" policies or strategy might be viewed as a necessary condition to recover a "failing" organisation, it is by no means sufficient. The organisation might still continue its decline by failing to implement the corrective strategies. Implementation entails putting the "strategy into place and getting the organisation to execute it" (Thompson Jr. *et al* 2005). Theoretical and empirical studies on strategy implementation and change suggest that difficulties in executing new strategies are rooted in two main areas: management of people and organisational processes. The former has been typically addressed by studies that focussed on the "dialectical tension", i.e. "the relative balance of power between opposing entities" (Garud and Van de Ven, 2002). Example of this includes the dispute between actors who want to change the organisation (*e.g*. C.E.O) with those who want to keep the status quo (*e.g.* employee union) (Meyer and Zucker, 1989). The latter comprises studies that point to the lack or insufficiency of some organisational capacities as source of failing implementation (Jas and Skelcher, 2005). Organisational capacities refer to the management technology or support systems, such as diagnostic control systems (Simons, 1995). The causes of faulty implementation highlighted by these two sets of studies will be the object of review over the next section.

Dialectical explanation of faulty implementation

Dialectical theory seeks to explain the sources of change or inertia in organisations by referring to the balance of power between opposing actors both internal and external to the organisation (Garud and Van de Ven, 2002). This theory holds that stability or inertia occurs when the struggle and mobilization of power between different entities result in the maintenance of the status quo. On the other hand, changes take place when the power of opposing groups is mobilized to a degree sufficient to challenge and suppress the current paradigm (ibid).

The idea of dialectical tension between groups has been used to explain why "failing" organisations fail to implement corrective action to turn their performance around. Meyer and Zucker (1989) contend that a persistent organisational failure or, in other words, the failure of an organisation to bring about effective changes to turn its performance around, is due to a stalemate between those collective actors who depend

on the current organisational template and those who want to change to improve the performance of the organisation. These authors maintain that under conditions of low-performance the "*owner*", or its equivalent, of the organisation is motivated to change it, whereas those actors who depend on the organisation want to maintain it. Once there is a convergence of interest and collective action on the part of those who depend on the current organisational template, the motivation to maintain it is transformed into an effective power to do so (ibid). Hence, when this motivation to maintain organizations is transformed into effective power, initial low performance evolves into sustained low performance, generating the so called "*permanently failing organisation*" (Meyer and Zucker, 1989).

Meyer and Zucker (1989) assert that public sector organisations are more susceptible to the collective action problem due to their goal ambiguity and lack of market discipline. This goal ambiguity, they contend, might legitimate the action of dependent actors and force the "owner" to avoid or review the decision on change that would affect the dependent actors' interest.

Hardy's (1990) study of successful and unsuccessful turnaround attempts in public and private organisations offers empirical evidence that supports the argument on the power of collective action in offsetting managers' actions aimed at implementing retrenchment strategies to overcome financial pressures. She demonstrates that the failure to implement the strategies could be attributed to well-orchestrated opposition campaigns conducted by powerful interest groups, both internal and external to the organisation. Part of the cause, however, was also attributed to the way managers handled this issue (Hardy, 1990). According to the author the inability to deal with opposition groups and communication deficiencies precipitated the failure of the turnaround strategies.

The dialectical tension explanation for faulty action gains support also in the empirical work carried out by Jas and Skelcher (2005) on turnaround attempts in 15 English Local Authorities. By presenting the partial results of real-time observations of 4 turnaround attempts out of the 15 English Local Authorities studied, the authors revealed that divergence in interest between groups in organisation was an important factor that explained failure in turnaround attempts. The failure to overcome divergence between groups in organisations and to provide a new "alternative performance future"

were associated with a poor leadership exercised by political group and top management team (Jas and Skelcher, 2005).

Others studies in public sector organisations have also provided empirical evidence on the association between poor leadership and organisational failure (*e.g*. Andrews et al, 2006 and Joyce, 2004). In empirical studies conducted on 120 English Local Authorities, Andrews *et al* (2006) showed that of all other managerial or organisational variables used in the study to identify causes of organisational failure, it was weak leadership that displayed the largest and most statistically significant association. Weak leaders were characterised as being impulsive or inward looking, whereas good leadership displayed characteristics such as outward looking, vision, risk-taking and commitment to performance improvement. In the same vein, Joyce's (2004) analysis of a successful turnaround in Newham Council, UK, demonstrated that managerial leadership played an important role in avoiding and responding to organisational failure. We have more to say on leadership and performance improvement, shortly.

It can be implied from this argument that failure to introduce corrective actions to reverse the decline trajectory can be attributed to poor leadership. By leadership we mean "the incremental influence of position holders exercised via direct and indirect means to maintain and/or alter the existing dynamics in and of a system" (Osborn et al, 2002). Many authors have highlighted the role of leadership in situations where conflicts exist over allocation of resources and adoption of retrenchment or recovery strategies (e.g. Behn, 1980 and Osborn *et al*, 2002). Behn (1980), for instance, points out that leadership is crucial for recovery strategies because "conflicts that exist over allocation of resources cannot be solved without creating some losers".

Influence of management capacities.

Even in the case where a general consensus among the key actors regarding the need and direction for change is reached, the organisation may still fail because of the dysfunction or absence of managerial and organisational capacities deemed necessary to bringing about performance improvement (Smart and Vertinsky, 1977; Turner *et al*, 2004). The most cited capacities refer to management and financial control systems. The lack or insufficiency of these capacities has a significant impact on the

organisation's operational capability to perform the tasks deemed necessary for good performance.

Jas and Skelcher's (2005) empirical study of turnaround attempts in 15 English Local Authorities revealed that failed turnaround attempts were related to the absence of management control systems that enable the organisation to effectively monitor their activities, control their financial resources and maintain employee and managers accountable for the implementation. In an empirical study on causes of failure in English Local Authorities, Andrews *et al* (2006) found a strong association between weak performance information systems and organisational failure. Although the authors relate the use of performance information systems to the development and design of strategies, they are also instrumental to the implementation process. Other empirical studies have provided strong association between performance management and organisational performance. Research on turnaround in five Further Education colleges in England (Bailey, 2005) and on an English Local authority (Joyce, 2004) show that performance improvement was achieved due to careful and intensive use of performance information systems.

2.1.3 - Concluding remarks

The causes of organisational failure in public organisations have been attributed to factors both external and internal to the organisational context. We carried out a review of the literature on internal causes of organisational failure in terms of three constructs derived from the models of organisational decline, namely organisational blindness, inaction and faulty implementation. By selecting constructs from stage models of decline we did not intend to imply either a causal linkage nor a linear sequence of the stages. The intention was solely to place hitherto dispersed literature in the same context and space and to provide depth and scope in the study of organisational failure. The review of these sets of studies offers comprehensive insights into determinants of organisational failure. These determinants are summarized in the table 2.1.

Table 2.1 – Determinants of organisational failure

Cause of failure	Determinants
Failure to anticipate or detect changes in the environment	Absence of, or poor, scanning activity.
Inaction (unwillingness of managers to appreciate and act upon performance data)	capacity for action; Organisational attributes such as non-participative and centralized decision-making;
Faulty implementation and faulty decision	Managers' attribute such as poor leadership and lack or absence of management capacities such as management control systems.

Taken together the three kinds of literature examined in this section offer insights into the managerial and organisational factors that provide information as to why organisations go into decline and fail to respond to a declining situation. Questions arise as to what extent organisations recover by addressing only the causes of decline. In other words, is the recovery phase a "mirror image" of the decline phase? Some studies suggest that although successful recovery attempts resolve the main causes of failure there is also evidence to suggest that organisations undertake a wider range of measures, some of them not necessarily related to the causes of decline (Grinyer *et al*, 1988). Thus, a review of the literature on organisational recovery can offer additional insights into the organisational and managerial factors that determine the recovery of an organisation.

2.2 – Research on recovery of organisations

Organisational recovery has been defined as a process by which an organisation improves its performance to a standard it used to have or would now possess if it had followed the standard achieved by the industry's (or sector) leaders (Rumelt, 1995). In this research we say that a public service organisation has 'recovered' when it has improved its performance to a level considered as satisfactory or superior, after had been gone through a consistent period of unsatisfactory or poor performance.[2]

To date, the vast majority of the research on recovery has sought to identify "generic" strategies associated with performance improvement of "failing" organisations (i.e. the 'content' of strategy) (see Hoffman, 1989, Pandit, 1996, Ketchen, 1998 and Boyne, 2006). Surprisingly, very few studies have sought to explain recovery by looking to the process by which recovery strategies are formulated and implemented

[2] See Chapter 3, page 57, for a detailed account on how we operationalise organisational recovery.

(e.g. Harker and Sharma, 1999; Filatotchev and Toms, 2006; Moore, 1995; Jas and Skelcher, 2005 and Hardy, 1991). In this section we examine these two kind of empirical studies. We are particularly interested in the managerial and organisational processes that explain recovery in organisations. In other words, what are the determinants of recovery in public sector organisations?

2.2.1 Research on the content of recovery strategy

The vast majority of empirical studies on organisational recovery have focussed on the "content" of effective recovery strategies. These studies typically apply regression analysis to measure the association between particular categories of strategies and turnaround. Three categories of generic strategy can be distilled from this empirical literature. The first pattern, known as "**retrenchment**" (McKiernan, 2003) or "decline-stemming strategies" (Arogyaswamy *et al,* 1995), consists of short-term actions aimed at stopping the decline and stabilizing the organisation. The second pattern is "**Repositioning**" (Boyne, 2004, 2006; Arogyaswamy *et al*, 1995). Repositioning comprises actions that involve a refocus on market or product/service, or significant changes in the core activities, or technology of the organisation. The third pattern of recovery strategies refers to actions at the operational level (Pandit, 1996), also known as "**Reorganisation**", aimed at improving the operation of existing strategy or giving support to a repositioning strategy (Boyne, 2006).

While a significant number of empirical studies have supported the association among these three categories of actions with performance improvement, most of the authors stress that these actions taken in isolation say little, if anything, about the recovery of organisations (Pandit, 1996). Turnaround is a complex situation, informed much more by a combination of actions taken over a period of time than by an isolated action. The way these actions are combined to bring about recovery varies enormously and depends on the specific situation and context within which the organisation is immersed (Slatter, 1984). As McKiernan (2003) puts it, the complex manner by which the actions interact makes it situation unique, thereby calling "for a customization of the recovery actions to a particular context".

Some authors have identified some characteristics of the context that influence an effective turnaround strategy (Pandit, 1996; McKiernan 2003; Slatter, 1984;

Hambrick and Schecter, 1983; Robbins and Pearce, 1992). According to these authors the major contextual factors that inform the choice of an effective turnaround strategy are the causes of decline, severity of the decline and attitudes of stakeholders. Most authors on turnaround agree that appropriate recovery actions should address the causes of decline (McKiernan, 2003). As McKiernan (2003) stresses, "managers could get it wrong by responding to the efficiency problems by changing strategy and the strategy problems by choosing belt-tightening policies internally." In an empirical study of 25 companies which achieved a sharp and sustained improvement in performance (called "sharpbenders"), Grinyer *et al* (1988) found that "a large portion of what sharpbenders did to achieve their success was to reverse the cause of their previous relative decline, where this lay within their power, and to change the way the firm reacted when it was not".

Severity of decline has also often been cited as affecting the choices of recovery action. The availability of spare resources in a decline situation may preclude entrepreneurial actions which require additional investment, such as product-market reorientation (McKiernan, 2003). Powerful stakeholders can also influence the recovery process by either directly dictating which recovery actions should be given priorities (*e.g.* Banks and Government) or, indirectly, by constraining implementation of some recovery strategies (*e.g.* employee union) (McKiernan, 2003; Slatter, 1984).

One characteristic of the vast majority of the studies addressed in this section is that most of the insights on the actions and contextual factors influencing recovery are drawn from private sector organisations. This leads to the question of the applicability of this conception to public sector organisations, as well as the extent to which the above mentioned actions and contextual factors can explain recovery in public sector organisations. While private sector organisations are relatively free to choose the market they want to serve or product they want to offer, public sector organisations are constitutionally required to provide a determined set of activities to a defined market. Boyne (2004:100) illustrates this more clearly,

> "…health authorities cannot diversify into the leisure and tourism market by providing hotels with fitness centres, even though this might contribute to the achievement of their mission. Similarly, social security benefit offices are not

empowered to move into the banking market, although their technology and skills in moving money might be suited to this form of diversification."

The same reasoning applies to the case of the repertoire of internal actions (especially retrenchment) available to public organisations (e.g. measures to reduce costs, such as firing employees might not be possible in some countries due to legislation that imparts stability to public servants).

Notwithstanding the distinctive characteristics of the environment of public sector organisations, Boyne (2006, 2004) maintains that these three kinds of generic recovery strategies are also feasible in the case of public sector organisations, albeit with a more limited set of substrategies than in private sector. By reviewing eight cases of public sector turnaround published in the literature on public management, Boyne (2006) identified instances of recovery strategies that fit into each of these three kinds of strategies. Strategies of retrenchment were found in five of these eight cases, and included downsizing the organisation (e.g. cut in Staff and equipments) and reduction in the supply of services. Four organisation pursued strategies of repositioning, either by refocusing their priorities within the existing market or by extending the scope of its operation (e.g. by contracting in a manufacturing service that it used to contract out). Lastly, reorganisation strategies were found in all cases examined, which included changes in management team, new performance management system and decentralisation of power.

In a later work, (with Meier, 2009) Boyne applied regression analysis over a large-scale sample of 140 Texas schools to measure the association between variables related to the three categories of strategies and performance improvement. The results revealed that turnaround is significantly associated with both repositioning and reorganisation. However, regarding retrenchment strategies, the results yielded a significant association between cutting-cost actions and recovery, but in an opposite direction. This result suggests that "in contrast to the evidence on private organisations, this form of retrenchment appears to be a route to further failure rather than rapid recovery" (Boyne and Meier, 2009). This has not come to be a surprise since the performance improvement was measured in terms of effectiveness criteria (improvement in educational test scores), rather than financial or efficiency-related criteria, as frequently used in private sector turnaround research. This result provides

strong support for the assertion that the correct turnaround strategies, especially in the public sector might depend on the criteria by which the success of the organisation is measured.

However, while these studies have shed light on the generic strategies and contextual variables which inform their choices, they say little, if anything, on "how" these recovery strategies are formulated and implemented. The process whereby strategies are formulated and implemented has often been taken for granted. Yet it can be argued that the processes of strategy formation and implementation are as important as the strategies themselves. Good strategies if badly implemented can lead to organizational failure. What determines the choices and effective implementation of a repositioning or reorganisation strategy deemed necessary to recover the performance of the organisation? In the next section we review the empirical studies that have sought to gain insight on the determinants of recovery by looking at the processes whereby managers choose and implement effective recovery strategies.

2.2.2 - Research on the process of recovery

Some studies have attempted to explain organisational recovery by looking at the process by which managers formulate and implement effective recovery strategies (e.g. Harker and Sharma, 1999; Filatotchev and Toms, 2006; Moore, 1995; Jas and Skelcher, 2005; Hardy, 1990, Joyce, 2004). Longitudinal case studies are typically applied to grasp the temporal development of events leading to organisational recovery. In these studies, recovery is examined as a sequence of actions or steps leading to performance improvement rather than a set of categorical variables (c.f. Van de Ven, 2007) as used in studies of the previous section. Disappointingly, very few studies that adopt a longitudinal case study research design to grasp the temporal element of turnaround, with an academically acceptable methodology, have been found in the literature. Of these studies, two were carried out in private sector organisations (Harker and Sharma, 1999; Filatotchev and Toms, 2006), two in public sector organisations (Moore, 1995; Jas and Schecter, 2005) and one in both public and private sector organisations (Hardy, 1990).

Harker and Sharma (1999) applied a longitudinal case study research design over a matched pair of two successful and unsuccessful cases of turnaround in private

companies in Australia to examine how the turnaround process had been led and managed. The findings of their study reveal that one of the critical differences of the turnaround and non-turnaround lies in the way organisational leaders develop and apply "industry wisdom". According to the authors, industry wisdom is achieved by carrying out a series of activities related to environmental scanning, such as research and analysis of information regarding market and customer needs and behaviour, as well as through experimentation using control groups and small samples to test efficacy of proposed policies and procedures.

A capacity to develop and negotiate the organisation's destiny was instrumental to gain support from key stakeholders on the proposed course of actions. Finally, organisational enhancement was achieved through measures aimed at improving the organisation's operations management capacity, including competent and costumer-oriented employees, improved communication due to a flexible and flat structure, incentives for individual, team and organisational successes, use of cross-boundary work and multi-functional teams to explore and solve problems, enhanced accountability of managers and workers and a shared understand of the business vision and the stakeholders' need (Harker and Sharma, 1999).

Other empirical studies have supported the need to negotiate and gain the support of key stakeholders during the recovery process (Filatotchev and Toms, 2006; Hardy, 1990). By analysing the success and failure of several companies during the decline and turnaround process of the textile industry in Britain, Filatotchev and Toms (2006) highlight the need to realign the economic interest of key stakeholders, especially financial ones, as a precondition to implement recovery strategies. According to the authors realignment of expectations between managers and key stakeholders is required so that "principals [stakeholders] see the opportunities in terms of revised expected returns arising from agents' proposed turnaround strategies." Hence, realignment of expectations and interests works as stages which imposes a threshold that must be crossed before implementing the recovery strategies (ibid.)

While Filatotchev and Toms' (2006) model is focussed exclusively on the importance of satisfying some economic condition in the relationship between turnaround managers and key stakeholders, Hardy (1990) shows that turnaround has also a political dimension that needs to be considered. By drawing from a longitudinal

study of 9 cases of successful and unsuccessful turnaround in both public and private organisations she puts forward a framework in which appropriate turnaround strategies are contingent on both economic and political pressures from the organisational environment. She goes on to suggest that successful implementation of these actions depends on a series of managerial tasks which include the management of awareness, employee involvement, communication and understanding of the actions process.

Regarding public sector literature, the processual nature of turnaround is captured in the longitudinal case-study research of 15 English Local Authorities carried out by Jas and Skelcher (2005) and Turner *et al* (2004). The authors use an inductive approach to build a theory of turnaround in public sector organisations based on some of the capacities and capabilities needed to cope with identified causes of organisational failure. By presenting the partial results of a real-time observations of 4 turnaround attempts out of the 15 organisations studied, the authors contend that organisational failure is due to: lack of leadership capability to overcome the collective action problem highlighted by Meyer and Zucker (1989); failure to achieve an internal coherence and resource to build a coalition for change; failure of the organisational cognitive system to appreciate data on performance decline; and lack of organisational capacity to implement the strategy developed by the leadership. Jas and Skelcher (2005) proposed then that the path to turnaround entails a sequence of initiatives to cope with the three factors relating to the organisational failure, namely lack of an appropriate cognition, leadership capability and organisational capacity.

The importance of leadership capability, organisational structure and managerial process is also emphasised in the work of Moore (1995). By means of a case study research design Moore (1995) provides a rich account of how the top mangers of two poorly performing U.S public organisations, namely Boston Housing Authority and the Houston Police Department, succeeded in delivering "public value". Moore (1995) contends that turnaround in public service organisations can be achieved by leadership that focuses on both the political and managerial aspects of both the internal and external environment.

Regarding the political dimension of external environment, effective leadership is necessary to build political support from key political stakeholders and gaining additional resources. Moore (1995) goes on to show that leaders gain political support

"by embracing accountability and negotiating the terms of their accountability to overseers". In the managerial dimension, effective leaders organize co-production with clients and catalyse the effective participation of citizens in the delivery of the public service. For instance, the Boston Houston Police Department' managers realized that they could not improve the performance in apprehending offenders and producing community security unless citizens participate in alerting officers to crimes and taking some responsibility for self-defence. In this sense, as Moore (1995) puts it, "citizens, clients and governmental organisations coproduce the value attributed to public sector organisations".

As for the internal environment, Moore (1995) showed that turnaround leaders influence organisational performance partially by promoting change in administrative structure, but also by establishing internal accountability, exposing managers to their customer (citizens) and focussing the organisation tasks on products and processes that move the organisation towards the main valued strategy. In both organisations, the leaders broke down "their centralised structure to get their organisations closer to citizens and clients and more open to street-level initiatives" (Moore, 1995). Management control systems were also needed to establish an internal accountability system that allows the manager to define performance standards, allocate challenging operational assignments to employees and hold decentralized units accountable for performance (Moore, 1995).

The importance of leadership characteristics and the performance management control is also examined in a later study carried out by Joyce (2004). By analysing leadership behaviour in the successful turnaround of Newham Council, in England, Joyce (2004) demonstrates that the successful recovery was associated with leadership behaviour characterised by developing and communicating a desired vision of the future, acquiring detailed knowledge of the organisation's performance and the community within which it is immersed, intense engagement in management, making employee accountable for performance (establishing internal accountability), negotiating support of their visions internally with employees and externally with key stakeholders.

The studies of Moore (1995) and Joyce (2004) reveal that the behaviour of leaders of a successful recovery attempt is more complex than traditional literature on

transformational leadership (i.e. creating and communicating vision that inspire and motivate employee to do more than they originally expect to do) and transactional leadership (i.e. monitoring performance of employee and exchanging rewards for compliance) (Burns, 1978, Bass, 1985), or the distinction between managers and leaders (Kotter, 2001) suggest. While the managers are concerned with dealing with the organisational complexity, for instance, by using planning and budgeting to set targets and establishing steps to achieve them, leaders are focussed on providing a vision of future "along with strategies for producing the changes needed to achieve that vision" (Kotter, 2001). Moore (1995) and Joyce (2004) showed that the distinction between leaders and managers in a recovery situation is blurred. Indeed, leaders are active both in providing a new vision of the future and managing the organisation. For instance, in both cases of recovery examined by Moore (1995), the leaders were active in providing a new direction for their organisations and, at the same time, in personally using and adjusting the administrative system to achieve their new vision, notably by establishing internal accountability and monitoring the performance of employees.

The main conclusion that can be drawn from the studies reviewed in this section is that recovery is the result of a process by which managers implement concrete actions to change the strategic orientation and/or administrative arrangements of the organisation. This process relies on the organisational acquisition and deployment of a series of intangible assets, such as skills, abilities and expertise of organisation, which might be called "capabilities" (Ulrich and Smallwood, 2004), that allow the organisation to cope with both managerial and political demands. By organisational capabilities we mean the organisation's intangible assets that "enable an organisation to conceive, choose and implement strategies" (Barney, 1992). This finding is consistent with other studies on organisational change which highlight that in the face of declining performance and hostile environment the challenge for the organisation is to acquire and develop key intangible assets, such as ability to lead change and environmental assessment (Pettigrew and Whipp, 1991). It can be drawn from the empirical studies examined in this section that the difference between turnaround and non-turnaround lies in the way organisations acquire and develop the capabilities shown in table 2.2.

Table 2.2. Determinants of Recovery

Capabilities	Source
Appreciation of market/sector and customer needs	Harker and Sharma, (1999); Moore (1995);
Active and engaged Leadership	Moore (1995); Joyce (2004); Turner *et al* (2004); Jas and Skelcher (2005); Hardy (1990)
Customer (citizens, community) connectivity	Moore (1995);
Embraced accountability	Moore (1995); Joyce (2004); Harker and Sharma, (1999);
External stakeholders involvement in service delivery	Moore (1995);
Management control	Moore (1995); Jas and Skelcher (2005)

Appreciation of market/sector and customer needs. This capability refers to the organisation's ability to gather and use information on the organisation and its environment that have a bearing on its performance. It includes knowledge of both operational (i.e. costumer behaviour and needs, suppliers and technology) and broader context (i.e. economics, social, cultural and political aspects of both the local community and the nation). This intangible asset is instrumental to managers in their attempt to recovery their organisations as it enables organisations to identify new market segments, niches and opportunities and provides clues on new ways of winning and retaining business, including new products and enhanced value-added services (Harker and Sharma, 1999).

Active and engaged leadership. This capability refers to the manager(s) ability to create, communicate and negotiate a new vision of future, embrace external, political accountability and engage in the organisation operation's management by using and adjusting internal accountability systems to monitor and reward (or punish) employees for performance results. Research has shown that a decline situation always requires manager to come up with a new way to operate, whether by repositioning the organisation in the market, by reorganising its operation in the existing market, or by retrenching its operation (Boyne, 2004, 2006). Whichever is the strategy adopted, conflict is likely to arise between manager and other stakeholders who oppose to the new strategy (Meyer and Zucker, 1989). Resistance is likely to be expected, since conflict over allocation of resources cannot be resolved without creating some losers (Behn, 1980) or placing employees in an insecurity situation of having to learn how to do the new tasks. This requires an ability to create a climate which will be receptive to

the new vision and strategies, and might involve justifying and persuading key actors on why the changes are necessary (c.f. Pettigrew and Whipp, 1991: 165). Lastly, active and engaged leadership also involves a determination to make change happen. This entails an engagement with operational issues, notably planning and performance management systems, to provide details of tasks that need to be done and to make employee accountable for performance.

External stakeholders involvement in service delivery. This capability refers to the organisation's ability to engage and coordinate the participation of the customer/clients for the effective co-production of the service. It is influential to the process of performance improvement in two senses. First, it engenders and stimulates the involvement of the community, or in other words "the user", in the delivery of the services. The "user" involvement in the implementation or delivery of the services helps to create a collective buy-in, that is an increased receptivity and support from the wider community (Leonard-Barton, 1995; Moore, 1995). Secondly, one feature of "service" production which distinguishes it from manufacture production is that the former is typically produced with the involvement of the client (Lovelock, 1992). For example, delivering community security by a police department cannot succeed unless citizens take some preventive actions or alert officers to crimes (Moore, 1995). Hence, by managing the external stakeholders involvement in service delivery, the organisation can enhance the quality and level of participation of the community in the delivery of the services. Conversely, an inward management may have a negative impact on the efficiency and effectiveness of the service delivery.

Management control. This capability refers to the organisation's ability to set goals and standards, measure and monitoring outputs and link incentives to goal achievement. Simons (1995) highlights that management control systems, by allowing the setting and monitoring of the achievement of critical performance variables, are essential levers for implementing intended strategies. An effective management control allows recovery managers not only to diagnosis the causes of failure, but also to make employees accountable for the achievement of critical performance targets (Simons, 1995).

Customer connectivity. This capability refers to the organisation ability to get their operations close to customer/clients. This capability is resonant of the

"Excellence" literature, particularly to the principle of "*getting closer to customer*" (Peter and Waterman, 1982). Such a capability makes it easier for the organisations not only identify the needs of customer but also to respond to them (Moore, 1995). Getting close to the citizens (clients) subjects the organisation to the demands, criticisms and expectations of the community, which, as a consequence, render the organisation more responsive to the community concerns (Ibid). By being exposed to the customer, organisations also improve the capability to mobilize co-production in the provision of the services. Moore (1995) demonstrated that by decentralizing their operations organisations can get closer to the customer. This not only helps the organisation to improve their performance, but also to become continually responsive to clients community concerns (Ibid).

Embraced accountability. This capability refers to the organisation's ability to encourage employees to accept and become accountable for performance. Ulrich and Smallwood (2004), point out that "performance accountability becomes an organisational capability when employees realize that failure to meet their goals would be unacceptable to the company". Getting employee accountable to the performance contributes to implement new recovery strategy because it has the potential to enhance the employee's commitment to their new roles. At the same time, it helps to shift the organisations attention from worries and speculations about new strategies (or bosses) to the specific tasks the bosses have handed out (Moore, 1995).

This section has examined two kinds of empirical research design on organisational recovery. It shows that the dominant pattern consists of studies employing cross-sectional research designs, combined in many cases with quantitative regression analysis, to measure the association between some strategies with organisational recovery. This confirms the assertions of Pettigrew *et al* (2001) that most studies on organisational change still remain an "exercise of comparative statics". While these studies identify a wide range of strategies associated with recovery, they say little, if anything, on "how" recovery strategies are developed and implemented. The static view provided by cross-sectional regression analysis overlooks the complex, dynamic and historical nature of the recovery process and, consequently, provides only a partial and possibly biased view of the process. As Abbott (2001: 183) points out, social reality happens in a sequence of actions located "*within a constraining and enabling structure*". Disappointingly, very few studies have focussed on the historical

development of the process of turnaround over time. Furthermore, no empirical comparative longitudinal case studies of a matched pairs of failing public sector organisations and those that have experienced turnaround have been conducted so far. Therefore, we still know very little about the dynamics of turnaround in organisations, in general, and in public organisations, in particular.

Thus far we have discussed the determinants of organisational failure and recovery. We identified a set of intangible assets, which we call capabilities, that enable organisations to conceive, choose and implement recovery strategies. However, some author argue that the measures that lead a failing organisation to recover do not necessarily ensure that it will be able to sustain the good performance in the long run (McKiernan, 2003). As McKiernan (2003) puts it, "it is one thing to successfully negotiate a recovery from a position of threatened extinction but quite another to be able to sustain it and learn from it". One obvious reason is that the conditions under which recovery strategies and processes have been designed and implemented can be expected to change over time. This implies that in order to sustain good performance in the long run, an organisation must be able to develop new processes and/ or changes in its product/market domain in order to adapt or take opportunity of changing conditions (Floyd and Lane, 2000). This leads to the question of what capabilities does a "recovered" public sector organisations need to sustain good performance in the long run? In order to answer this question, in the next section we examine the literature on the learning process that underlies the organisation's capacity to continuously improve or renew its process/products in order to sustain good performance in the long run.

2.3 - Research on organisational renewal

Some authors have added a final stage in the turnaround process, namely organisational "***renewal***" (McKiernan, 2003; Leavy and McKiernan, 2009; Harvey *et al*, 2004). This stage is characterized by measures aimed at sustaining the good performance of the recovered organisation in the long run, in order to prevent them from falling into decline again. By adopting these measures, organisations address the main, or primary, causes of organisational failure, which has been attributed to the "ossification" of the organisation and the dysfunction of the organisation learning system that preclude the organisation to anticipate and adapt to a changing environment (see section 2.1 above).

McKiernan (2003) identifies two characteristics of the renewal stage, namely the maintenance of managerial and organisational features that counted for good performance and the development of a learning process that underlies the continuous development of products and services needed to adapt to changing situations. The importance of maintaining key characteristics and activities developed during the recovery phase for sustaining performance has been empirically examined by Grinyer *et al* (1988).

The second characteristic of the renewal process entails the development of a learning capacity that underlies continuous development/improvements of process or product needed to sustain the good performance in the long run (McKiernan, 2003; Leavy and McKiernan, 2009). It is the organisation's capacity to learn that informs its ability to constantly improve the organisation's existing product and services, as well as to create novel products and processes. The extent to which organisations can learn faster than others has been considered as a source of competitive advantage (Pettigrew and Whipp, 1991), or comparative advantage in the case of public service organisations. The main challenge for managers to sustain good performance in the long run is thus to create the right learning mechanisms that enable them to "*exploit*" ways to implement/deliver existing policies and services and to "*explore*" innovative policies and services (March, 1991). But what are the organisational and managerial capabilities that allow organisations to learn? In other words, what determines whether an organisation has a learning capability or not?

The determinants of organisational learning that influence the organisations' ability to renew are often addressed by three kinds of literature, namely the 'twin' literatures of "organisational learning" (*e.g.* Argyris and Schon, 1978) and "learning organisation" (*e.g.* Senge, 1992), and the literature of knowledge and knowledge creation (*e.g.* Nonaka and Takeuchi, 1990 and Leonard-Barton, 1995). While the twin literatures or organisational learning and learning organisations are similar in many aspects, an important distinction between them stands out. The former is more concerned with theoretical studies of the learning process, which "primarily aim to understand and critique what is taking place" (Easterby-Smith and Lyles, 2003). This literature gained ascendancy since the seminal work of Argyris and Schon (1978), who popularised the distinction between "single-loop" and "double-loop" learning. The former is concerned with learning mechanisms that seek to improve the way of doing

things without challenging the theory of action that underlies the policies and strategy of the organisation. The latter involves questioning why things are done and results in changes of the theory of action underlying existing strategy and policies (Ibid).

Literature on learning organisations has adopted a more practical perspective and has sought to identify managerial and organisational characteristics that inform the learning capacity of the organisation. The normative foundation of learning organisation can be attributed to the work of Senge (1992). Senge (1992) claims that the learning organisations are made up of five "component technologies", namely, systems thinking, personal mastery, mental models, building shared vision and team learning. It is the extent to which an organisation masters these five components that distinguishes its learning capacity from other organisations (Ibid). His ideas have been shown to be highly influential and have been considered as a potential source of renewal and growth in organisations (Easterby-Smith and Lyles, 2003).

Although the normative foundation of learning organisation can be traced back to the work of Senge (1992), the work of Pedler *et al* (1997) has helped to disseminate the "ideal" of learning organisations by providing a set of operational concepts of the determinants of a learning organisation. Although the ideal of learning organisations has attracted wide attention in the past 15 years from both managers and management scholars, "conclusive empirical evidence to support interventions seeking to develop the learning organisations is hard to find" (Hodgkinson and Sparrow, 2002).

Regarding public sector organisations, the few empirical studies that seek to examine the applicability of the ideal of learning organisation have provided mixed or inconclusive results (Common, 2004). In a general sense, more sceptical authors (e.g. Common, 2004; Wallace, 1997; Edmonstone, 1990) contend that peculiar characteristics of public organisations, such as the imperative of accountability (in the sense of being accountable for the work, avoiding mistakes and a high level of detail of the work that must be done) and ambiguity of goals, preclude the applicability of the "ideal" of learning organisation in this domain. On the other hand, the empirical study conduced by Smith and Taylor (2000) on four U.K civil service organisations reveals that "the effect of public accountability in limiting progress towards the learning organisations ideal is overstated in the literature." In the same vein, Reschenthaler and Thompson (1996) propose that the emergence of the New Public Management

administrative philosophy has a potential to engender the establishment of the learning organisations in government.

A different approach has studied organisational renewal by focussing on the knowledge creation process in organisations (e.g. Nonaka and Takeuchi, 1995). Floyd and Lane (2000) define organisational renewal as "an evolutionary process associated with promoting, accommodating, and utilizing new knowledge and innovative behavior in order to bring about change in an organization's core competencies and/or a change in its product market domain." Empirical studies have connected knowledge and knowledge-creating activities with the organisations' ability to generate new routines or improve existing ones in order to sustain long term performance (*e.g*. Iansini and Clark, 1994; Leonard-Barton, 1995; Zollo and Winter, 2002; Verona and Ravasi, 2003). These authors address the issue of organisational renewal by identifying the knowledge base and activities that underlie the organisational ability to explore new products and/or processes in order to adapt to or anticipate changing circumstances and, as a result, achieve long-term performance.

Although the three kinds of literature (organisational learning, learning organisation and knowledge creation) might have a different thrust, employ different language and appeal to distinct audiences (Hodgkinson and Sparrow, 2002) they do share a similar perspective regarding the determinants of organisational renewal. Literature on knowledge creation and the twin literature of learning organisations and organisational learning suggest that learning and constant improvement of the organisation is determined by the organisation ability to acquire/generate knowledge and to integrate new knowledge on the organisations' process and routines. These abilities have been defined as "*learning capability*" and considered as the driving force for continuous improvement of an organisation's performance (Ulrich *et al*, 1989).

The concept of learning capability has been operationalised in term of the extent to which organisations make use of a set of organisational activities and characteristics that enable them to generate new knowledge and integrate this knowledge within the organisation. The organisational characteristics elements that make up a learning capability most frequently researched in the literature are: shared problem-solving activity with individuals with diverse specialisation; use of external knowledge

acquisition mechanisms, experimentation and pilot projects; human resources and leadership approach towards learning; and use of performance feedback.

Shared problem-solving activities. This activity refers to the organisation's ability to integrate the diversity of specialization, functions, roles and cognitive styles in problem solving. Island, or 'fiefdom', of specialization, promotes divisiveness within organisations and increase the likelihood that problem solving will be approached by an idiosyncratic perspective, or limited knowledge base. The inability to integrate the diverse specialisation in problem solving results in sub-optimal decision and limits organisational creativity (Leonard-Barton, 1995). Empirical studies have shown that the organisation's capacity to acquire and integrate new knowledge in the organisation is related to its ability to integrate the diversity of specialisation in problem-solving (Iansiti and Clark, 1994; Leonard-Barton, 1995). This ability to integrate the diverse specialization into problem-solving is operationalised in term of the extent to which an organisation makes use of integration mechanisms, such as multi-functional teams and boundary spanner. Boundary spanners are staff members whose primary function is to coordinate information about projects, process or customer across different specialisations within the organisation (Gittell *et al*, 2005)

Use of external knowledge acquisition mechanisms. This element of a learning capability refers to the organisation's ability to recognise the value of new, external information. Looking outside their boundaries helps organisation to generate new knowledge "because technological knowledge comes from a very diverse set of sources, the wider managers cast the net, the more likely a prize will be caught within it" (Leonard-Barton, 1995). Benchmarking "best practices" has been the commonplace of the external knowledge acquisition mechanisms (Ulrich *et al*, 1989). By benchmarking "best practices" organisations "generate ideas by going outside their boundaries and learning what other companies do" (Ibid.)

Experimentation and pilot projects. One of the difficulties in developing new products and processes lies in the uncertainty related to initially workably solutions and in the fact that technical knowledge is often contestable (Leonard-Barton, 1995). Thus, experimentation and pilot projects are useful as a learning mechanism to validate the new product/process design. By means of feedback loops from experiment or pilot projects, managers can generate new knowledge which might be useful to improve the

organisation's operations and services. As Wheelwright and Clark (1992) put it, "if the action-outcome-feedback linking are short and frequent, the individual is in good position to learn about, and thus comprehend, the probable effects of actions on outcome: short links enhance the ability to improve decision making by taking corrective actions." This element of learning capability can be operationalised in terms of the extent to which the implementation of a new process or project in the organisation is preceded by experiment or pilot projects followed by systematic activities to discuss insights gathered from the pilots.

HR management approach to learning. Researchers have shown that the employee skills and managerial systems (especially incentives and rewards) are key components of the organization's knowledge base (Leonard-Barton, 1995; Verona and Ravasi, 2003). Whilst the former function as a source of knowledge accumulation, the latter act as the channels through which knowledge is accessed and flows (Leonard-Barton, 1995). The way organisations encourage the development of knowledge and skills, and the movement of employees, through and up, the organization have an important effect on the organisations' learning capability. Extensive training programmes and systematic rotation of managers across the organization contributes to the generation and integration of new knowledge across the organization (Ulrich *et al*, 1989). Similarly, managerial systems to incentive and reward behaviour that promote learn is an important element of learning capability. As Ulrich et al (1989) highlight, "since employees are likely to do what they are rewarded for, these management actions will foster sharing and generalization of ideas with impact across boundaries."

Leadership approach to learning. The nexus between leadership and learning has become more evident since researchers have endeavored to explore the managerial actions and context that affect learning. For some authors the notion of learning has even become part of the very definition of leadership. Berson *et al* (2006), for instance, defines leadership as a "process of influencing and teaching others to understand why and how certain activities and goals need to be accomplished. As such, it constitutes a process of facilitating individual and collective efforts to learn and accomplish shared goals in organizations." In this sense, leadership affects learning because leaders facilitate the individual and collective efforts towards learning and create the favourable condition within which learn can flourish.

Theoretical models have associated leadership behaviour to both single-loop learning (or exploitation) and double-loop learning (or exploration) (e.g. Berson et al, 2006; Vera and Crossan, 2004). Edmondson's (1999) empirical studies of 51 teams, demonstrates that learning behaviour in managers team is increased when the team leaders behaviors create an environment of psychological safety (i.e. "a share belief that team is safe for interpersonal risk taking"). The leader behaviour associated with team managers learning was found to be supportive, coaching-oriented and with non defensive responses to questions and challenge. Similarly, empirical research carried out by Amitay *et al* (2005) at 44 community clinics of a health-care organization in Israel, found a strong association between organisational learning and transformational behaviour of leadership (i.e. that emphasizes the idealized influence, individualized consideration and inspirational motivation and intellectual stimulation by leaders (Bass,1996)). The rationale behind these findings is that such leadership behaviour creates, enables, and inspires a psychologically safe environment that discourages the use of "defensive routines" (Argyris and Schon, 1978; Edmondson, 1999 and Amitay *et al*, 2005). These empirical works suggest that the learning capability is associated with a transformational behaviour of leadership.

Performance feedback mechanisms. Argyris (1977) defines organizational learning as the process of "detecting and correcting error". In this sense, the organisation's ability to detect error is *sine qua non* of organizational learning. The use of performance feedback mechanisms is then essential for detecting error, thereby enabling learning in the organization (Greve, 2003). Important feedback mechanisms in public sector are the evaluation organisations carry out or commission in order to assess the impact, effectiveness or efficiency of some of their strategies or programmes. As Leeuw and Sonnichsen (2000) put it, "whether the terms are 'process evaluation', 'formative evaluation', 'program monitoring,' or 'economy and efficiency audits,' the intent is the same: find out what is going on so that responsible decision makers can make the necessary corrections and modifications to keep the program on track."

Whilst the literature on learning and knowledge-building has grown in popularity and interest in private sector management literature, it has nonetheless attracted less attention among public management scholars. No empirical studies were found that address how public sector organisations develop the capabilities needed to sustain good performance in the long run. This leads to the question of the way in which

the concepts of the determinants identified in this literature can be operationalised in public sector organisations: how do public organisations balance the requirement of "fairness" and "due process" (Rainey, 1997), for instance, with the need of more flexible organisational process and organisational climate that stimulate experimentation and tolerate errors? How can knowledge-absorption mechanisms be achieved in a context of frequent turnover of top managers due to elections and political appointments? The literature has thus far been silent regarding these questions.

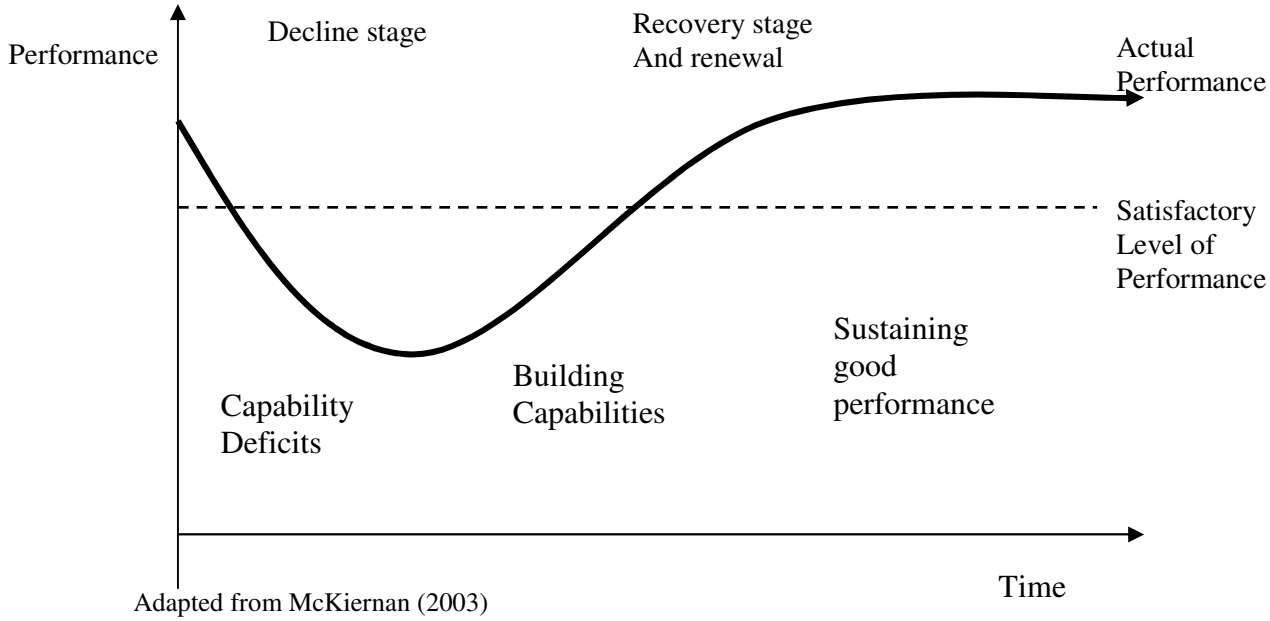
Table 2.3 Determinants of continuous improvement and renewal

Capability	Elements that make up learning capability	Source
Learning capability	- Shared problem solving with individuals with diverse skills and background;	Leonard-Barton (1995); Iansini and Clark (1994); Verona and Ravassi (2003); Senge (1990); Pedler *et al* (1997); Gittell *et al*, (2005)
	- Learning approach to policy or strategy formation, through experimentation and pilot projects;	Wheelwright and Clark (1992); Leonard-Barton (1995); Pedler *et al* (1997)
	- Use of external knowledge acquisition mechanisms such as gatekeepers, boundary spanners, continuous interaction with outside source of information	Ulrich *et al*, (1989); Leonard-Barton (1995); Pedler et al (1997); Iansiti and Clark (1994)
	- HRM approach towards learning	Ulrich *et al*, (1989); Leonard-Barton (1995); Verona and Ravassi (2003);
	- Leadership approach towards learning	Berson *et al* (2006); Vera Crossan (2004); Edmondson (1999); Amitay *et al* (2005); Bass (1990, 1996); Argyris and Schon (1978);
	- Use of performance feedback mechanisms	Argyris (1977); Greve (2002); Leeuw and Sonnichsen (2000).

2.4 – A synthesis – building capabilities to recover and renew public service organisations.

In this research we argue that the notion of capability, defined as the organisation's intangible assets that "enable an organisation to conceive, choose and implement strategies" (Barney, 1992), can also be translated, to some advantage, to the conceptual domain of organisational recovery[3]. From this standpoint, the decline or "failing" stage can be viewed as a phase in which the organisation lacks some essential capabilities needed for good performance. Accordingly, the recovery and renewal phase of the turnaround trajectory can be thought of as a process by which the organisation builds up and deploys the capabilities deemed necessary for long-term performance (see figure 1.2).

Figure 2.2. Influence of capabilities on an organisation's performance



Adapted from McKiernan (2003)

An advantage that accrues from applying the capability approach to the study of recovery is that the concept of capability is "developmental", in the sense that it allows

[3] Another theory to explain the source of heterogeneous performance of organisations (in terms of competitive advantage) is the Resource-Based View of the firm (see Wernerfeld, 1984). According to this theory it is the ownership of resources, which can be tangible and intangible, that account for the differences in firms' performance. To the degree that a firm capability, as defined in this thesis, is based on its resources (e.g. intangible assets) the resource-based view certainly encompasses capabilities (Saloner et at, 2001). However, some authors distinguish between capabilities and resources. Grant (1991) maintain that resources are the inputs to the production process whereas capability is what an organisation can do with its resources – i.e. a team of resources working together to make an organisation capable to perform some valuable function. I this research we do not make such a distinction since we consider the ability to perform some task (e.g. capability) as also a resource (intangible asset) that an organisation owns.

the analysis of the development of a series of capabilities over time that explain the different trajectories across organisations in their attempt to recovery their performance and sustain it in the long run. A further advantage is that the capability perspective provides an integrative approach to study the process of recovery and renewal. Recovery and renewal should be viewed as intertwined processes, rather than two distinct and separated stages or phases in the turnaround trajectory. Existing literature on recovery and renewal has tended to treat them as two separated phases or stages, often analysed through a different theoretical lens. One weakness of this 'stagist' approach is that, in practice, it is difficult, if not impossible, to pinpoint exactly when the measures taken to recover end and the renewal begin. It is the capabilities built to recover the organisation which will also inform the organisations' ability to renew, *i.e.* create new processes and products to adapt to a changing environment. Thus, we argue that the "capability" perspective offers a coherent apparatus to study the organisational development process of a "failing" organisation that encompasses both the recovery and renewal processes of organisations.

But what are the capabilities organisations need to turn their performance around and sustain them over the long haul? Our review of the literature on failure, recovery and renewal offers insights on the capabilities needed to recover good performance and sustain it in the long run. The combined approach of these three literatures was necessary to provide depth and scope in the study of turnaround. A composite table of the capabilities that explain recovery and renewal of organisations is shown below (table 2.4).

Table 2.4 Determinants of decline, recovery and renewal

<table>
<tr><th colspan="2">Organisational failure (capabilities deficit)</th><th>Organisational recovery (building capabilities)</th><th>Organisational renewal (sustaining good performance)</th></tr>
<tr><th>Cause of failure</th><th>Capabilities Deficits</th><td rowspan="4">- Appreciation of market/sector and customer (sensing capability)
- Leadership capability
- Customer (citizens, community) connectivity
- supportive external environment (e.g. External stakeholders involvement in service delivery)
- Management control (including accountability)</td><td rowspan="4">- Learning capability.
- maintaining the capabilities developed to recover.</td></tr>
<tr><td>Failure to anticipate or detect changes in the environment</td><td>Absence of or poor environmental scanning ability.</td></tr>
<tr><td>Inaction (unwillingness of managers to appreciate and act upon performance data)</td><td>Capacity for action.</td></tr>
<tr><td>Faulty implementation and faulty decision</td><td>Poor leadership and lack or absence of management capacities such as management control systems.</td></tr>
</table>

The analysis of the table above reveals a closer connection between the causes of failure and the capabilities needed to both recover and sustain good performance in the long run. Most of the capabilities needed to prevent organisations from falling into decline and responding to failing situation are to some extent included in the capabilities organisations need to recover and sustain good performance. For instance, the determinants of the organisation's failure to detect and anticipate changes are connected to the organisation's capability to appreciate market/sector and costumer, and the learning capability. Similarly, the poor leadership capability highlighted as an important cause of failure to respond to decline is also presented in the literature on recovery as an important capability to turn the performance around. This reinforces the findings of previous studies that highlight the necessity to address the primary causes of failure as a condition to recover and sustain good performance in the long run (*e.g* McKiernan, 2003).

Chapter 3 – Research Strategy and Design

3.1 - Themes and Questions for Empirical Research

By drawing on the literature of both private and public sector, we stated how the notion of capabilities can be used to explain the recovery and renewal of organisations. In particular we identified a set of determinants of recovery and renewal as the capabilities "failing" organisations need to improve their performance. It is the capabilities deemed necessary to recover the organisational performance and sustain it in the long term that forms the basic theme of our empirical research. This leads to our four general questions for empirical research:

Question 1. What capabilities do "failing" public sector organisations need to improve their performance?

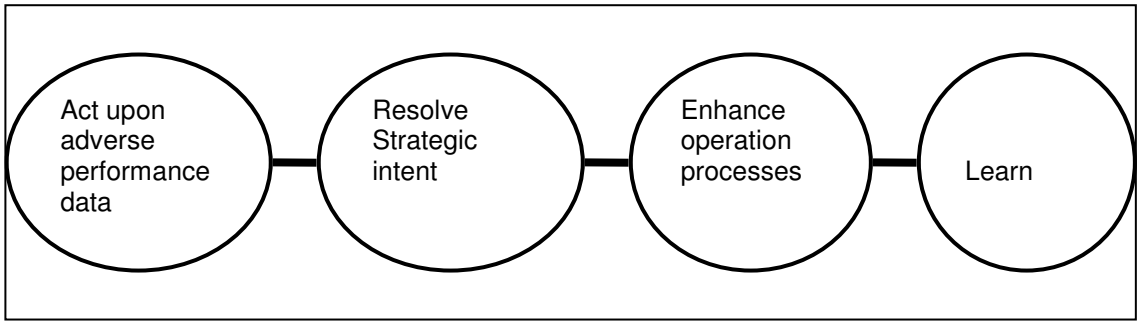
Question 2. Why are those capabilities so crucial in explaining performance improvement?

Question 3. How can these capabilities be built and applied?

Question 4. To what extent are those capabilities complementary, in the sense that the performance effect of one is increased with the presence of the others?

Throughout the literature review we mentioned that "failing" organisations recover when they develop the ability to act upon adverse performance data, to overcome actions and power from opposing internal and external stakeholders (resolve strategic intent) and to enhance operation processes. We also mentioned that organisations can sustain their good performance when they are able to learn and modify the operating process in pursuit of improved effectiveness (see diagram below).

Figure 3.1 – process of recovery and renewal



3.2 – Ontological and epistemological assumptions

A research design and outcome is affected by the researchers' position regarding the nature of reality and what is, or should be, considered acceptable knowledge on the topic. The former refers to the ontology whereas the latter to the epistemology that underpin the design of the research (Easterby-Smith *et al*, 2002; Bryman and Bell, 2003). The purpose of this section is, therefore, to make explicit our ontological and epistemological stances and explain how they will affect our research design and methodology.

Ontological Assumptions. Discussion on the nature of reality has concentrated on the question of whether reality is external and independent of social actors or whether it is socially constructed (Bryman and Bell, 2003). These two polar views of reality have often been referred to as objectivist and subjectivist (or social constructionist), respectively (*Ibid*.). In a nutshell, the objectivist view assumes that the social phenomena and their meaning have an existence that is external and is beyond the influence of social actors (Bryman and Bell, 2003). In contrast, social constructionists assert that reality is not external and objective, but rather determined and given meaning by people (Easterby-Smith *et al*, 2002).

In this research we reject this polar view of reality and assume an ontological position that acknowledges the existence of an objective reality but also recognize that our knowledge of reality is mediate by our theoretical preconceptions. This ontological perspective is similar to what Pettigrew (1997b) has termed "mediativist" view of knowing. According to this ontological stance, "social circumstances intervene by mediating between nature and accounts of nature, but do not eliminate the effect of nature" (Pettigrew, 1997b: 286). In our research we are interested in a set of intangible

assets (which we call capabilities) whose existence or effect explains the recovery of a "failing" organisation. Our argument in this research is that it is exactly the existence of these intangible assets that explain the recovery or renewal of organisations. In this respect, we assume that these capabilities are real, but our knowledge about them is shaped by our concepts and theories. Moreover, we also recognize that reality is dynamic, as opposed to a steady and immutable state. In this sense, in this research we follow Sztompka's (1991) notion that reality is in a permanent state of "social becoming".

Epistemological assumptions. Acceptance of a particular ontological perspective influences the epistemological stance of the researcher. As Bryman and Bell (2003) point out, "questions of social ontology cannot be divorced from issues concerning the conduct of business research". The polarization between the ontological stances discussed in the above paragraphs, leads also to extreme epistemological perspectives, namely positivism and interpretivism. The former is related to an objectivist view of reality while the latter is consistent with a subjectivist ontological perspective. Briefly, positivists hold that the object of enquiry exists externally and independently of the researcher and that "its property should be measured through objective methods, rather than being inferred subjectively through sensation, reflection or intuition" (Easterby-Smith *et al*, 2002). A corollary of this concept is that only theoretical terms that are amenable to direct and objective observation are acceptable as explanations of the phenomena (Bryman and Bell, 2003). According to this tradition, replicable findings yielded through prescribed procedures are the assurance that they are, in fact, "true" and independent of the investigator (Guba and Lincoln, 1994). Interpretivists, on the other hand, state that the subjective and complex nature of the social world can not be grasped through the objective and "detached" methods proposed by positivists. Interpretivism attempts to reduce the distance between the researcher and the object of inquiry, as well as to provide methods of enquiry that grasp the subjective meaning of social phenomena (Bryman and Bell, 2003)

.

These two extreme stances, taken separately, are inconsistent with our ontological stance, which recognises both the existence of a reality and its effect but acknowledge that our knowledge of the reality is mediated by social circumstances and preconceptions. Difficulties in gaining access to, or apprehending the reality, particularly due to "flawed human intellectual mechanisms and the fundamentally

intractable nature of the phenomena" (Guba and Lincoln, 1994), lead to some variants of the positivist stance. A recent variant of the stance has accepted some mechanisms underlying the observable phenomena as having real impact, whether they are observable or not (Easterby-Smith *et al*, 2002). This epistemological stance has been labelled Critical Realism. Unlike positivism, critical realism assumes that reality exists but the researchers' conceptualization of reality is simply a way of knowing that reality (Bryman and Bell, 2003; Guba and Lincoln, 1994). Hence, the critical realists is happy to accept mechanisms that account for observable phenomena that might not be measured through objective methods (as positivists claim), but rather inferred subjectively (Bryman and Bell, 2003) and accept interpretative method (Easterby-Smith *et al*, 2002). Due to the difficulty in apprehending reality the claims about reality must be subject to the widest possible critical examination (Guba and Lincoln, 1994). In this sense, "critical realists make a conscious compromise between the extreme position: it recognizes social conditions (such as class and wealth) as having real consequences whether or not they are observed and labelled by social scientists; but it also recognizes that concepts are human constructions" (Easterby-smith *et al*, 2002).

In this research we make assumptions about the nature of knowledge that are similar to those made by critical realists. The main reason for assuming this stance is that we believe the complexity of the recovery process in organisations cannot be grasped and fully understood by focusing only on some objective methods that can be quantitatively measured or tested. As we discussed in the previous sections most empirical studies on organisational recovery have been underpinned using positivist assumptions. They are often characterized by using quantitative methods, notably regression analysis, coupled with a cross-sectional research design, in order to test hypotheses concerning the association between some independent variables (strategies) and dependent variables (performance improvement). However, organisational recovery is a multifaceted and dynamic process and, as such, some of its facets will certainly not be directly amenable to objective observation, but are extremely important to understanding the "what", "how", "when" and "why" of recovery and renewal.

The complexity of turnaround processes demands a certain degree of interpretation that the positivist tradition centred in the static and direct association between variables cannot provide. Furthermore, the process by which organisations build or employ the capabilities deemed necessary to recover and sustain good

performance cannot be captured through this research tradition, since organisations "are analysed through cross-sectional, rather than longitudinal perspective" (Tsoukas and Knudsen, 2002). The epistemological tradition of critical realism is thus consistent with the processual and complex nature of organisational recovery and renewal, thereby enabling a richer account of the underlining mechanisms that inform the success of the recovery process.

3.3 – Research strategy and design

3.3.1 – multi-strategy research design

In this research we adopt a multi-strategy research design, which combines the strengths of quantitative and qualitative methods. The reason for employing a multi-method approach is threefold: to afford a "*between-method triangulation*" that has the potential to increase the validity of the research (Snow and Thomas, 1994); to improve the accuracy in the analysis of the interconnection between the independent variables (capabilities) and their weight in the process; and to increase significantly the external validity of the findings regarding the capabilities associated with recovery.

We have argued that both 'persistent failure' and recovery of a public service organisation can be explained by a deficit and development, respectively, of a set of capabilities. Hence, the main research questions we seek to answer in this research are: "what capabilities do public service organisations need to recovery and renew; and how can they be built and exploited?" In the qualitative part of this research we propose to answer this question by employing comparative and longitudinal in-depth case studies in a sample encompassing one successful case of turnaround and one case of less successful organisation (see next section). Evidence to support our explanatory model would be obtained by looking at regularities and differences in the presence and use of a set of capabilities across these two organisations over time. However, since the recovery of organisations is linked to a wide range of interconnected capabilities, such regularities and/or differences in the use of some capabilities might not be clearly evident by analysing only a limited number of case study organisations. Quantitative methods, on the other hand, can inject more accuracy in answering this kind of "what" question by more precisely measuring the association between the use of these capabilities across successful and less successful recovery attempts in a larger sample of organisations. Therefore, the introduction of quantitative analysis affords a further

element of triangulation in the research, in which the findings of the qualitative methods can be cross-checked with and reinforced by the findings of the quantitative analysis. This "*between-methods*" triangulation has the potential to increase the validity of the findings (Snow and Thomas, 1994: 474).

Secondly, the use of the quantitative method in this research has also a complementary purpose. One of our research questions is related with the complementarities of the capabilities. The precise analysis of the complementarities of capabilities, however, is not possible to be conducted in qualitative research. By using quantitative analysis, notably multiregression models, it is possible not only to identify the capabilities associated with recovery, but also to measure with more accuracy the degree of interconnection and complementarity between them and the weight of each capability in the process of recovery and renewal.

Lastly, one of the critiques, and perhaps the most forceful, of an in-depth case study approach concerns the external validity of its findings, *i.e.* the generalizability of the findings beyond the confines of the context within which the study was conducted (Bryman and Bell, 2003). External validity is strong when the research is carried out in a representative sample of the population, which entails a much larger sample than is feasible to be covered by in-depth research. The time and complexity involved in an in-depth case study research reduce the feasibility of its application in a large sample. Thus, by combining an in-depth longitudinal research design with a cross-sectional analysis carried out over a more representative sample, we significantly increase the external validity of the findings.

3.3.2 – Qualitative part – longitudinal and comparative case study

We have identified the longitudinal and comparative case study as the most appropriate approach for exploring the process by which organisations build a set of capabilities needed to recover and sustain good performance in the long run. The reason for selecting this approach is threefold. Firstly, our research questions require us to examine how the development and deployment of a set of capabilities over time accounted for the improvement of the organisation's performance and its maintenance as a continuous process. In order to do this, it is necessary to have longitudinal data which allow us to grasp the temporal interconnectedness of the recovery and renewal

processes (Pettigrew, 1990). Yin (1994) stresses that when the research questions deal with operational links that need to be traced over time, rather than to frequency or incidence, then the case study method is the most suitable.

Secondly, the longitudinal case study is considered to be a powerful approach to grasping the complexity of the transformation process in organizations (Pettigrew, 1990). By allowing the analysis of the temporal development of a process within a context, a longitudinal case study makes it possible to "reveal the multiple sources and loops of causation and connectivity so crucial in identifying and explaining patterns in the process of change" (Ibid:271). This is relevant to our research because our case studies are accounts of the transformation process by which the organizations build and deploy capabilities needed for long term performance.

Finally, the case study method has proven to be advantageous in situations where we know little about the process under analysis. In this situation, Eisenhardt (1989) points out that one of the strengths of case studies is that they help to generate novel theory. This strength lies in the fact that case studies allow the juxtaposition of contradictory or paradoxical pieces of evidence, and that its resultant theory is likely to be testable and valid. In the same vein, Ragin (1997) asserts that the case study method allows concept formation because it "stimulates a rich dialogue between ideas and evidence." Therefore, the case study method seems to be the most appropriate to apply to this research because we know very little about the process of recovery and renewal of public service organisations. Furthermore, no study has linked the process of recovery and renewal with the notion of "capabilities" and the capability-building process.

3.3.2.1 - Selection criteria for the case-study organisations.

The criteria used to select the research sites are as important as the research design itself. However, before selecting the organisations to be studied, it is necessary to define the population from which the sample can be drawn. Defining the population sets the limits of generalizability of the findings and helps the researcher to control potentially confounding variations (Eisenhardt, 1989). In this research we have chosen public acute hospital trusts in England as the potential population from which the sample of organisation will be drawn.

The reason for choosing acute hospital trusts in England as the site for research is fourfold. Firstly, acute hospitals are, together with schools and police departments, the most common kind of public service organisations in the U.K and many countries around the world. However, public hospitals can be distinguished from the other public service organisations as they are often larger and have more complex professional bureaucracies (Mintzberg, 1983), as well as consuming a larger amount of financial resources. These make the study of the recovery and renewal of public hospital trusts both academically interesting and economically relevant. Secondly, by choosing cases from the same sector (i.e. Health sector) and the same country (England) we can control some sectoral and cross-country environmental variations, thereby reducing "extraneous variation" across the studied organisations (Eisenhardt, 1989).

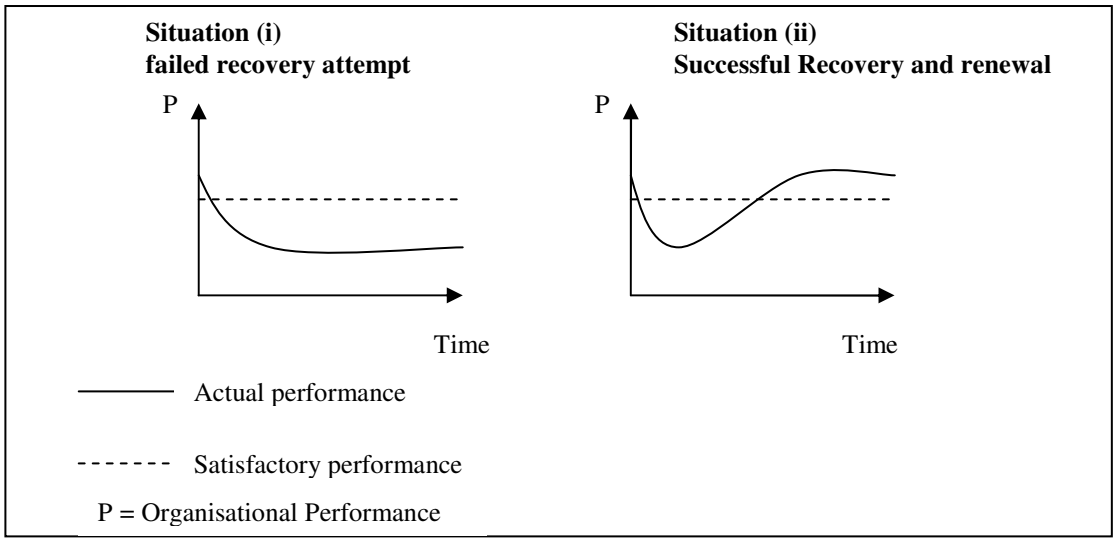
Thirdly, all acute trusts are subjected to the same accountability systems that measure and rate the organisations' overall performance in relation to the quality of services and use of resources (all acute hospital trusts are subject to the same annual evaluation process that rates them as weak, fair, good or excellent). This accountability system enables us to identify and compare the evolution of the organisations' performance over a considerable period of time. The availability of time series data showing the evolution of performance indicators over time is the *sine qua non* of empirical study on the process of recovery in organisations. Finally, the Chief Executive Officer of each hospital trust is directly accountable for the performance of the trust and, at the same time, has relative discretion and motivation[4] to manage in order to achieve value for money from the available resources (Department of Health, 2006).

Having defined the population, the next stage of the research design requires the definition of the criteria by which the case-study organisations are selected. As Eisenhardt (1989) asserts "while the cases may be chosen randomly, random selection is neither necessary, nor even preferable". Pettigrew (1990) argues that if we are interested in the links between organisational capabilities and performance it makes sense to choose polar types, which reflect extreme situations illustrating low and high performance.

[4] See section 2.1.1 for a discussion on the incentives for managers to bring about performance improvement, notably Bevan and Hood (2006)'s discussion of "target and terror" governance system.

By following the advice of Eisenhardt (1989) and Pettigrew (1990), we chose to conduct the empirical study using two public service organisations which illustrate two different outcome of the process of recovery. These situations are: (i) one case of a "failing" organisation that went through several unsuccessful turnaround attempts and took longer to embark in a successful turnaround trajectory and (ii) one organisation reflecting a case of a well-orchestrated successful turnaround attempt. These two extreme situations can be illustrated in the graphs below.

Figure 3.2. longitudinal performance of successful and failed recovery attempts[5]



A comparative analysis of the situations (i) with (ii) should highlight the capabilities that are linked to the organisational recovery and those that organisations need to sustain good performance as a continuous process, thereby avoiding falling into decline again.

Another important decision that needs to be made in selecting the cases is the period of time a decline in the performance should be regarded as a failing situation. Literature on turnaround in the private sector has typically operationalised this period of consistent failure as 2 to 4 years (Pandit, 1986; Hambrick and Schecter, 1983). In contrast, there are few empirical studies of recovery in public organisations to provide parameters of the period of time in which a public organisation should be regarded as a failing organisation. Boyne (2006) argues that the definition of a consistent period of

[5] The purpose of these graphs is merely to provide a visual illustration of the three situations. We are by no means arguing that the organisations of this research have necessarily a satisfactory performance at their initial stage (time = 0). In fact, some public organisation could be failing organisations since the beginning of their operations (see Jas and Skelcher, 2005)

poor performance should consider the nature of the services being delivered and the frequency with which the performance data is collected. In the case of acute hospital trusts, data reflecting the performance of the organisation in terms of quality of services and use of resources are collected annually. Hence, for the purpose of this research we identify successful case of recovery and renewal as those in which the organisations' performance had been below the satisfactory level for at least two years followed by an upturn in performance, reaching a good performance level. This period is consistent with other studies on recovery and should enable the identification of "sustained" good performance, as opposed to a fleeting fluctuation in the organisation's performance.

Following these criteria, by analysing the time series of data showing the performance of acute hospital trusts since 2001, when the "star rating" system was firstly introduced, we identify the following organisations as potential sites for empirical work:

Table 3.1 – Potential case study organisations
Situation (i): cases of less-successful recovery attempts.
Situation (ii): case of successful recovery

Situation	Acute hospital trust	Performance ratings								
		2001	2002	2003	2004	2005	2006 (Q)	2006 (UR)	2007 (Q)	2007 (UR)
(i)	Hospital A	*	Zero star	Zero star	*	*	fair	weak	weak	weak
(ii)	Hospital A - HOSPITAL A	Zero star	Zero star	Zero star	* *	*	good	fair	excellent	fair

Q = quality of service
UR = Use of resources

Table 3.1 demonstrates that the two hospital trusts followed two distinct performance trajectories since the introduction of the performance rating system in 2001. During the first three years both trusts received a very poor score and thus can be considered as "failing" organisations according to this performance rating system. However, from 2004 the performance of the trusts started to follow distinct trajectories. While there was a slight improvement in the overall score of Hospital B, from "zero star" in 2003 to "one star" in 2004 and 2005, its performance remained below a performance level considered as "good", returning to the lowest level of performance again in 2007 when it scored "weak" for both "use of resources" and "quality of services". By contrast, during the same period there was an upturn in the HOSPITAL

A's performance, from three consecutives "zero star" in the beginning of the period to "excellent", the highest level of achievement, in 2007 – the end of the period under analysis.

3.3.2.2 – Gaining Access.

Gaining access to case materials is something that is inherently problematic for this kind of research. Two particular characteristics of the research sites (public hospital trusts), however, make the access for this research still more challenging. Firstly, we should expect that CEOs and top managers in these organisations are extremely busy and under pressure to satisfy a wide range of demands from a diversity of stakeholders. Secondly, we should expect that gaining access to poorly performing organisations might be particularly difficult. This is likely to raise a sensitive issue, as senior managers might consider that this research will further expose their organisations as instances of "failing" organisations.

In order to overcome these issues we made use of a series of measures that substantially increase our chances of getting access to our potential research sites. We found Buchanan *et al*'s (1988) advices on how to negotiate access to organisations particularly useful in this research. These included: the exploitation of personal networks as fully as possible; dealing positively with respondents' reservation with respect to time; offering a tangible and valuable product (report of our findings) in return for cooperation.

The first measure, and perhaps the most forceful, was implemented by taking advantage of the existing network that my supervisor has built with senior managers and CEOs of the NHS system during his research on hospital trusts in England. His own reputation as an internationally respected scholar, together with the professional and trusting relationship he was able to build with key managers of UK hospital trusts, was crucial in helping me to gain access to the research sites. Secondly, managers' reservation regarding time was dealt with by anticipating that interviews would not be time-consuming and that they could be held at any time they wish, including lunch time and even evenings. Lastly, reservation regarding an eventual exposure of the organisation as an instance of a "failing" organisation was addressed by anticipating that the findings, in form of a report, would be firstly offered to the organisation, which

would be asked to highlight sensitive points. Furthermore, we anticipated that this report would contain information that might be extremely valuable to the manager's efforts to recover the performance of their organisations. Taken together these measures were instrumental to get access to the two research sites.

2.3.2.3 – Ethical Approval.

According to NHS regulations, any researcher that wants to carry out research involving potential access to NHS premises and NHS Staff as potential participants should apply and gain Ethical Approval from the NHS National Research Ethics Committee, prior to the beginning of the research. Thus, we submitted all application forms and documents on this research as requested by the NHS Research Ethics Committee in order to satisfy the requirement for getting ethical approval. The information about my research then went through a careful review process by the Committee. It was part of the review process a face-to-face interview with members of the Berkshire National Research Ethics Committee, which I and my supervisor attended. About two months after submitting the application, this research was granted the Ethical Approval by the aforementioned Committee.

In addition to the Ethical Approval from the National Research Ethics Committee it was also necessary to formally apply for approval from the Research Ethics Committee of each hospital trust we selected as case studies. Each organisation required virtually the same documents sent to apply for Ethical Approval from the National Committee, including the latter. Approval from the Local Research Ethics Committee of each organisation was then granted before we began the empirical work in the two selected Trusts.

As part of the ethical procedures, an "information sheet", contained information about the research and the interview process (see Annexe G), was previously sent to all potential participant, after an initial contact made by telephone with their personal assistants (p.a). Participants were also asked to sign a "consent form" (Annexe H), where they formally agreed participate in the research. In both "information sheet" and "consent form" it was stated that the identity of the respondents will be disguised. This meant that any quotation from the participants' response used in all reports and papers would be anonymous. However, during the interview process, some key actors who

have an active role in the transformation process formally agreed to have their identities disclosed in the research.

3.3.2.4 – Data Collection

The literature on research methods highlights two major methods of gathering qualitative longitudinal data when the focus of the research is on the process, namely real time participant observation and retrospective interviews (Bryman and Bell, 2003: 296). The two methods can inject a sense of process in the research. However, in choosing one of these methods, the researcher must consider some key operational issues that may preclude its appropriateness to particular cases of recovery in public sector organisations. Participant observation implies carrying out real-time research in an organisation that is going through a turnaround-focussed process. Two particular characteristics of this research pose considerable risk in carrying out participant observation. Firstly the efforts invested into the transformation process do not necessarily lead to performance improvement and recovery. In this case, what was initially supposed to be research into the process of recovery could end up being, at best, research into the factors that preclude organisations from turning their performance around, leading them to persistent failure situations. Secondly, a complete recovery and renewal process (situation "ii") can take several years. Hence, it would not be feasible to apply the participation observation method to study organisational recovery in a doctoral research on this topic.

Therefore, we considered retrospective interviewing as the most suitable method for gathering data. The three most common types of interview found in the literature are structured, semi-structured and unstructured. We considered semi-structured interviews as the most suitable type to be used in this research. The main reason is that semi-structured interviews use pre-established questions to guide the subject through fairly specific topics, while employing open-ended questions that allow interviewees freedom to digress (Bryman and Bell, 2003). Semi-structured interviews allow the researcher to generate data about critical incidents, by asking interviewees to "recall examples of specific events that illustrate each topic" (Ibid). Hence, by employing semi-structured interviews we can direct the interview process towards the pre-defined topics we want to explore (see Appendix F, page 296), while giving the interviewees the chance to link their answer with other related topics and for new topics to emerge. Furthermore, semi-

structured interviews provide a consistent format that ensures comparability of our case-study organisations used in this research (c.f. Bryman and Bell, 2003). The topics were explored by asking respondents questions regarding some features of the organisations during the "failing" period, including its processes, structure and managerial culture and attitude; the key source for change from both the external context; the key interventions and initiative to turn the performance around implemented over the timeframe of analysis.

3.3.2.5 - Time frame of the study

In order to obtain longitudinal data using retrospective interviews, interviewees are also asked to reflect upon specific events in the past. This, together with documentary analysis, helps to build issue-organised chronologies of events related to the transformation process of each organisation studied. But what is the most appropriate time frame to grasp the succession of events involved in the development of capabilities needed to recover and renew the organisations? The definition of the period covered in the analysis of a transformation process is important because "time sets a frame of reference for what changes are seen and how those changes are explained" (Pettigrew, 1990:271).

While there is no definitive and precise answer to this question, we defined our timeframe to cover the period of 2000 to 2007. The reason to choose 2000 as the start point is due to the fact that the overall performance rating systems (the "star rating") was introduced around that year. Following the publication of the "star rating", a series of measure are taken to bring about performance improvement in "failing" organisations. "Zero- and one-star" trusts are required to submit to and agree a performance improvement with the SHA, which, in turn, has its improvement responsibility overseen by the Department of Health (Harvey *et al*, 2005). Key policies adopted by the latter have included "franchising" (change of management team) and external support through agencies specifically created to promote performance improvement in the "failing" organisations (e.g. Performance Development Team of the Modernisation Agency, from 2001 to 2005, and the Performance Support Team, from 2005) (Ibid). Hence, the publication of the first "star ratings" have been followed by measures that triggered the recovery process and thus constitute a suitable start point for the analysis. Fulop *et al's* (2004) empirical studies of failure and turnaround in UK

hospital trusts states that turnaround managers "plan their turnaround to run over a period of at least three years". Hence, we believe that the elapsed time of 7 years, since the publication of the first ratings, is sufficient to demonstrate the development of capabilities needed to recover and sustain good performance in the long run.

3.3.2.6 - Challenges in conducting historical analysis

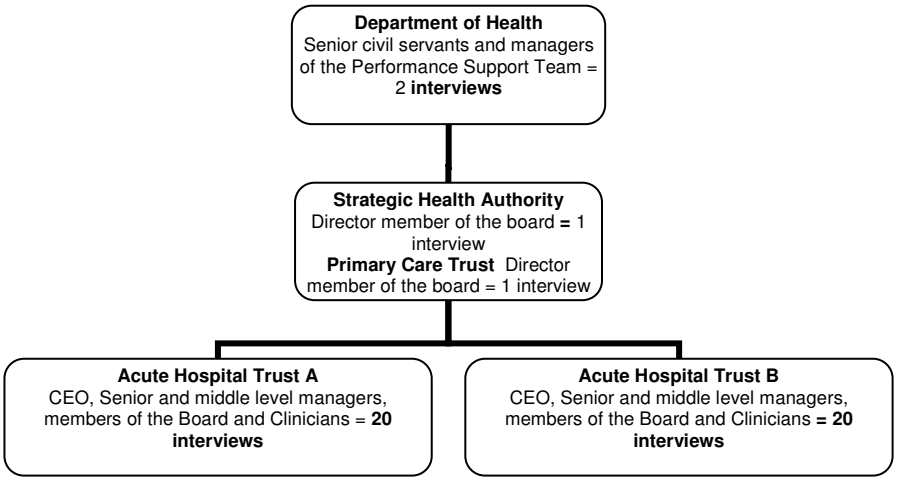
Although the use of narrative accounts of past events is necessary to inject a sense of process in the explanation of organisational recovery (Mahoney and Rueschemeyer, 2003), the use of historical methods adds specific challenges to our research. The main problems in gathering oral historical evidence are associated with the issues of reliability and validity (Dunkerley, 1988). The former refers to the reliability of the respondent's account due to the vagaries of the respondent's memory and bias introduced by distortion of emotions and motives (Ibid.). Validity refers to the extent to which the interviewee's response is influenced by the interviewer.

In order to circumvent the validity and reliability problem we made use of a number of techniques that helped to overcome the bias introduced by the respondents' memory lapse and distortion, and reduce the interviewer influence over interviewees. These included building the narrative from the account of diverse interviewees who have participation or knowledge of the process under analysis, rather than relying on only one informant (see next paragraph). This helps to reduce the reliability problem because building a narrative from the perspective of diverse interviewees provides a more comprehensive account of the process, where one interviewee compensates for the possible memory lapse of the others, and reduces the possibility that the final account will be biased by the emotion or distortion of one interviewee. Triangulation with other documental sources is also useful in reducing the reliability problem. The issue of validity was dealt with by making use of existing interviewing techniques that helped to reduce the influence of interviewer over the interviewees' response. These included avoiding getting into a "real" conversation with the respondent in which the interviewer answers questions posed by the interviewee or manifests his/her opinion about the matter discussed (Fontana and Frey, 1994), and avoiding leading "probing" questions (Easterby-Smith *et al*, 2002).

The interviews were conducted with key people from each of the two selected organisations and from key stakeholders. Pluralism in the selection of the interviewees was adopted in order to obtain different perspectives of the transformation process and avoid bias in favour of a single view of the "drama" (Pettigrew, 1990). Since the performance improvement attempts in the trusts have a strong influence from the higher tiers of the NHS bureaucracy, data was collected from three levels: the acute trust level, the strategic health authority level and the department of health level (see diagram below). In the trust level, we interviewed about 20 people in each Trust. Interviewees in the trust level were selected on the basis of their leadership in the organisation and the change process under analysis, and their participation in and knowledge of the changes. Interviewees thus included the Chief Executive Officers, all executive director members of the board, top and middle level managers, and clinicians.

In the strategic health authority level we interviewed an executive director member of the board, who was involved in the strategic direction and performance management of the concerned trusts. We also included one interview of a Director of an external organisation responsible for commissioning the services of the concerned trusts (Primary Care Trust). In the Department of Health interviews was conducted with members of the team responsible for providing support to trusts that failed to achieve the standards and targets (Support Development Team). Hence, we obtained a comprehensive and holistic picture of the performance management process, as well as a balanced sample of around twenty informants for each trust (see diagram below). We believe this sample was enough to reach "*theoretical saturation*", in the sense that additional interviews would not provide new data on the topics under analysis (Glaser and Strauss, 1967; Strauss and Corbin, 1998). In order to ensure precision in the analysis of the interview data, all interviews were tape recorded and transcribed.

Figure 3.3. Interviews plan



Data from the case studies were also gathered from documentary analysis and observational notes. In this research, documentary data included internal documents, external audit and inspection reports, organisation history and statutes, internal reports, and meeting minutes. Although the reliability and validity of documentary data, in general, have been subjected to considerable debate (Hodder, 1994), when cautiously treated they have proven to be valuable sources of insights into the timing and context within which decisions were taken (Remenyi *et al*, 1998). Observational notes involve taking notes on some related process that can be observed during field work. As Pettigrew (1990) highlights, "observations can confront the researcher with discrepancies between what people have said in interviews and casual conversations, and what they actually do". Taken together these two sources of data can be used to triangulate and validate the information gathered from interviews (Pettigrew, 1990).

3.3.2.7 – Analysis of the Data

Dealing with the data gathered during the field work is perhaps the most difficult and the least codified task involved in conducting longitudinal case study research (Eisenhardt, 1989). This is not least because it entails capturing and making sense of the complexity of the social world (Pettigrew, 1990). The overwhelming burden of information, if not methodologically and systematically treated, can result in what Pettigrew (1990) has termed "*death by data asphyxiation*". In this section we set out the main tasks that were undertaken in this research to capture and make sense of the complexity of the real world and to avoid the pathway to data asphyxiation.

Huberman and Miles (1994) note that data analysis is an interactive process that occurs before, during and after data collection. This process, they maintain, comprises three subprocesses, namely data reduction, data display, and conclusion drawing and verification. This framework has been used by researchers doing processual qualitative analysis (*e.g.* Hatum, 2002) and has proven to be particularly strong in simplifying complex data (Pettigrew, 1990). Building upon Huberman and Miles' (1994) framework, we now detail the main steps and tasks towards data reduction, data display and conclusion drawing and verification that were taken in this research to analyse the data.

Data Reduction. This part of the data analysis process consists of reducing the potential universe of data both before data collection, through conceptual frameworks, research questions and instruments, and afterwards, by means of techniques to select and condense the data, such as coding, clustering and data summary (Huberman and Miles, 1994). In this research project, we did this by coding the data under broad categories, as shown in the interview pro-forma (Appendix F, page 296). In this way, data was coded and accumulated in categories such as organisations' "capacity for action", "sensing capability". In order to help us to code, store and retrieve the data we used the N-Vivo software.

Data Display. The aim of this phase is to obtain an organized and compressed array of information that enables the researcher to draw conclusions (Huberman and Miles, 1994). We identify the multi-level and issue-organised analytical chronology as the most suitable way to display the data and start to identify the capabilities organisations need to recover and renew, as well as how they can be built. The justification for this choice is that multi-level analytical chronology is compatible with both processual (Pentland, 1999) and contextual natures of the process by which organisations build the capabilities that lead to recovery and renewal. Furthermore, the analytical chronology is also considered as central to the generation of insights needed to build theory (Eisenhardt, 1989; Pettigrew, 1990). As Pettigrew points out, "analytical chronologies are prepared to get on top of data, to clarify sequences across levels of analysis, suggest causal linkages between levels, and establish early analytical themes."

The analytical chronology in this research was written around five themes related to the transformation process that led organisations to recover and renew their performance. These include the characteristics of the organisation during the decline stage, the key strategic initiatives, changes in structure, change in managerial processes and change in management. The sequence of events around these themes provides valuable data to explore how the development of key capabilities was important to the process of recovery and renewal of the organisations. For example, it might be possible to identify how the pattern of leadership behaviour, restructuring of the service delivery process and the use of management control systems were important to organisations' recovery and renewal.

Drawing conclusions and verification. This part of the analysis process involves drawing meaning from the displayed data (Huberman and Miles, 1994). This will be done through cross-case analysis. Cross-case analysis allows the researcher to identify similarities and differences that account for the phenomena under analysis and enhances the chance of encountering novel findings that might not be anticipated (Eisenhardt, 1989). In this research, cross-case analysis was carried out in organisations that have gone through a recovery process and those that faced difficulties in turning their performance around. These comparisons allowed us to identify capabilities needed to recover the organisational performance and sustain good performance as a continuous process.

3.3.3 – Quantitative part – Survey questionnaire

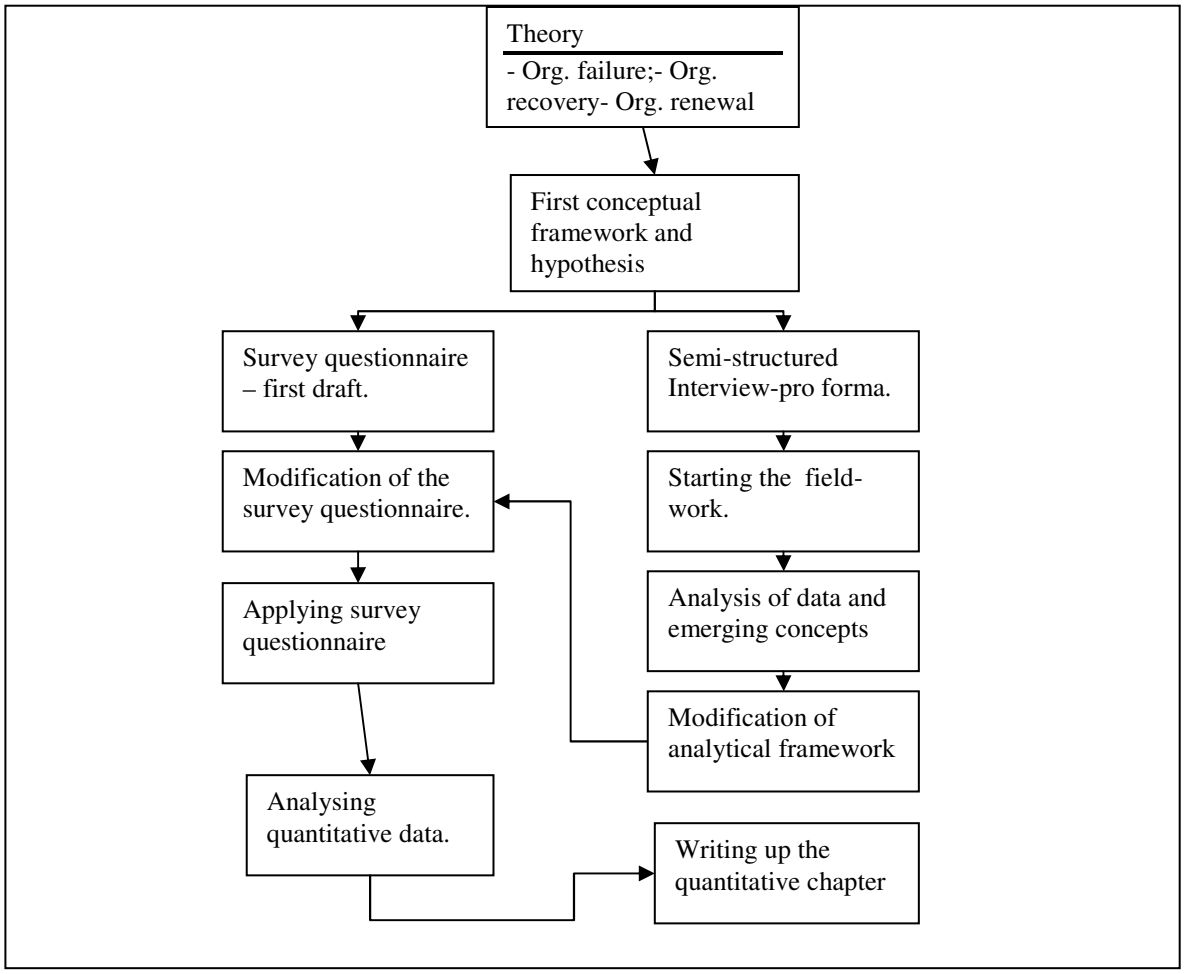
The purpose of using quantitative methods in this research was to obtain a more accurate and precise measure of the association between the use of capabilities and the overall performance of the trusts. We tested the hypothesis on the association between the performance of the organisations and the use of capabilities. Quantitative methods provide a measurement of the association between the performance of the organisations and the use of capabilities, as well as of the extent to which the capabilities are complements in the explanation of the performance of an organisation.

A self-completion questionnaire was sent to the CEO and three Directors of all acute hospital trusts in England (N=172). Respondents were asked to state the extent to which the organisational practices and features that comprise the capabilities have been used in the organisation.

The construction of the concepts and hypothesis tested using quantitative data analysis followed a two-stage process. In the first stage, we used a theory-driven deductive approach to build the initial constructs and hypothesis. This has been done during the literature review section, in which a set of capabilities needed to recover and renew organisations were distilled from theoretical and empirical studies on organisational failure, organisational recovery and renewal. The second stage consists of a data-driven inductive process, in which the initial framework was modified following the analysis of the first data gathered in the field work (see figure below). A detailed

description of the design and administration of the questionnaire, as well as all the steps conducted for the quantitative analysis is provided in chapter 8.

Figure 3.4 Key Steps of the quantitative data collection



3.4 – Concluding remark

In this chapter we presented our research strategy to investigate the process of recovery and renewal of public service organisations. We started by clarifying our research questions and by making explicit our ontological and epistemological stance that affected the methodology we designed to answer the research questions. We positioned our ontology within Pettigrew's 'mediativist' view of knowing, wedded with Sztompka's notion of reality as a permanent state of 'social becoming'. As for epistemology, we make assumption about knowledge that is similar to critical realism, which accepts presets of both positivist and interpretative methods. These stances influenced our choice of research methods as follows: we can use both quantitative and qualitative methods, as well as collect longitudinal data, to have a richer understanding of the process of recovery and renewal.

We therefore adopted a multi-strategy research design, which combines the strengths of qualitative and quantitative methods. We have also chosen to conduct the research on the population of acute hospital trusts in England. The research used a two-stage approach: in the first stage we applied longitudinal and comparative case studies to indentify how the development of a set of capabilities accounted for the recovery and renewal of two "failing" hospital trusts in England. In the second phase we use statistical model to measure the extent to which those capabilities are linked to performance of the hospital trusts in England and the extent to which they are complementary.

The results of our empirical work are presented in the following chapters. Chapter 4 provides an account of the changes in the policy context during the timeframe of analysis. This account enables us to identify the key challenges posed by the external context to the acute hospital trusts in England. Chapters 5 to 7 are the qualitative part of the research. In these chapters we present and analyse two case study organisations: one case of successful recovery and renewal trajectory and one case of less-successful recovery attempts. In chapter 8, we present and discuss the results of our quantitative models.

Chapter 4 - The Policy Context

4.1 - Introduction.

The management literature is replete with evidence about the influence of the external context on the functioning of organisations. Many authors claim that public sector organisations are even more subject to pressure and challenges from external context than their counterparts in the private sector (Rainey, 1997). This is mainly because public sector organisations are more embedded into the political context and have more complex accountability structures, which subject them to the direct or indirect influence of authorities who seek to control them. Furthermore, political turnover is often associated with new policies and changes in priorities, which bring along top-down pressure over organisations and the public inside them to deliver on these policies (Ibid), and impose short time-horizons on public managers (Boyne, 2002). The analysis of the change process within an organisation, therefore, cannot be dissociated from the analysis of the external context (Pettigrew, 1987).

The policy context of the NHS has been one of consecutive top-down policies and central government commitment to changes since its inception in 1948. The period from late 80's to the beginning of the first decade of this century, however, witnessed what has been considered the most radical changes in the organisational structure and dynamics of the NHS (Ham, 2004). Such a period of change has its origin in the election of the Conservative Government in 1979 and continued after the political change in 1997, when "New Labour", under Tony Blair, took over the government. For the purpose of this research, the analysis of the NHS broader policy and political context will comprise the 10 years of New Labour government, since the election of Tony Blair in 1997 to his resignation in 2007.

This chapter will discuss the major policies and priorities set for the NHS during this period and then move on to analyse in more detail the impact of these policies on NHS hospitals trusts. As major changes in health policies in UK are influenced by the Secretary of States for Health, we have structured the analysis of the policy context over the period of 1997 to 2007 by following the key initiatives of all secretaries of states for health in office during this period, namely Frank Dobson (1997-1999), Alan Milburn (1999-2003), John Reid (2003-2005) and Patricia Hewitt (2005-2007).

4.2 - The Frank Dobson Era (1997 – 1999)

The New NHS

The Labour party came into office in 1997 without a well-elaborated plan for reforming the NHS. Within the newly elected government the debate of ideas was marked by, on one hand, the New Labour pragmatism, for which 'what counts is what works', and, on the other hand, the 'Old Labour' rhetoric, which sought to refute the outgoing Conservative policies (Klein, 2007). Within the Department of Health this debate was internalized with the appointment of Frank Dobson as Secretary of State for Health, who adopted a more traditional 'old labour' rhetoric, and Alan Milburn, as Minister of State, who advocated a more pragmatic approach for health policy, thereby willing to maintain some of the Conservative government initiatives (Ham, 2004).

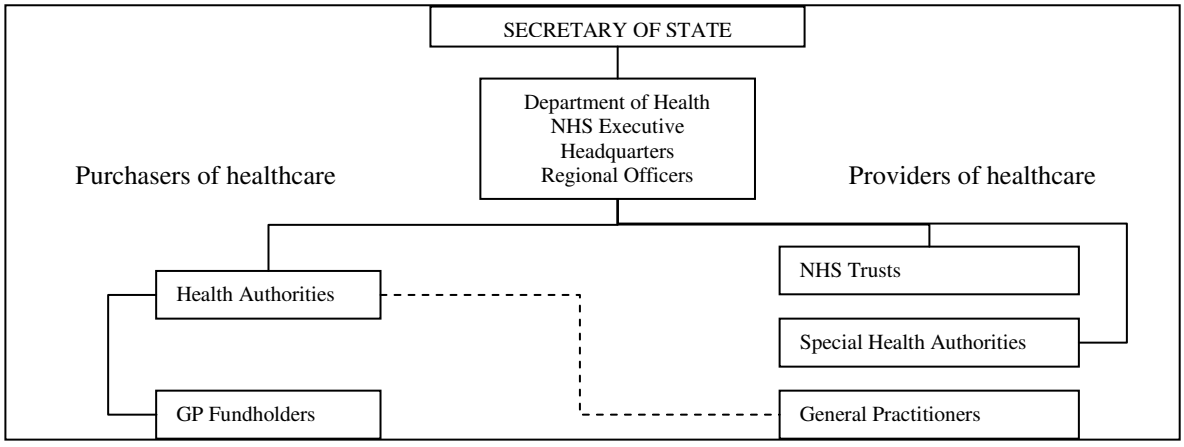
The first six months of Frank Dobson as Secretary of State for Health were then spent in the preparation of the plan for reforming the NHS (Ibid). This effort culminated in the publication, in December 1997, of the White Paper 'The New NHS: modern, dependable'. The White Paper explicitly acknowledged the government's intention to distance itself from both the Conservative policy, notably the 'internal market', though keeping some of its features, and the 'Old' Labour's command-and-control system. The White Paper's proposal to replace these two streams was dubbed 'the third way', which emphasised partnership, as opposed to competition, and more local participation and decentralization in the operation of the services, as opposed to the centralised command-and-control. As described in the White paper (Secretary of State for Health, 1997):

> "In paving the way for the new NHS the Government is committed to building on what has worked, but discarding what has failed. There will be no return to the old centralised command and control systems of the 1970s...But nor will there be a continuation of the divisive internal market system of the 1990s...Instead there will be a 'third way' of running the NHS - a system based on partnership and driven by performance."

The White Paper was reckoned to be both pragmatic, in the sense that it sought to maintain what worked from the previous government, and eclectic, as it was made up of a wide range of measures to improve the NHS, as opposed to the single core idea as that of 'internal market' which dominated the previous government (Ham, 2004). The major features of the White Paper were: a commitment to maintain the purchaser-provider split; a move towards more primary-care-led NHS, through the establishment of primary care groups as the provider of community health services and major commissioners of hospital services; and a strong emphasis on measuring and improving quality of services.

The previous Conservative government sought to improve the efficiency of healthcare providers by introducing market discipline into the delivery of public health services. The means used for this purpose was the separation of purchaser and providers of healthcare thereby creating an 'internal market' in which providers of healthcare competed for contracts (more precisely known as 'services agreement'). Within this arrangement, the major purchasers of healthcare were the District Health Authorities – DHA (Health Authorities from 1996) and the GP fundholders (community doctors that were given a budget to buy health services for their patients). Alongside the General Practitioners (GPs), the NHS trusts created from 1991 were the providers of most of the health services (see figure 4.1).

Figure.4.1 The Structure of the NHS before 'The New NHS' reform.



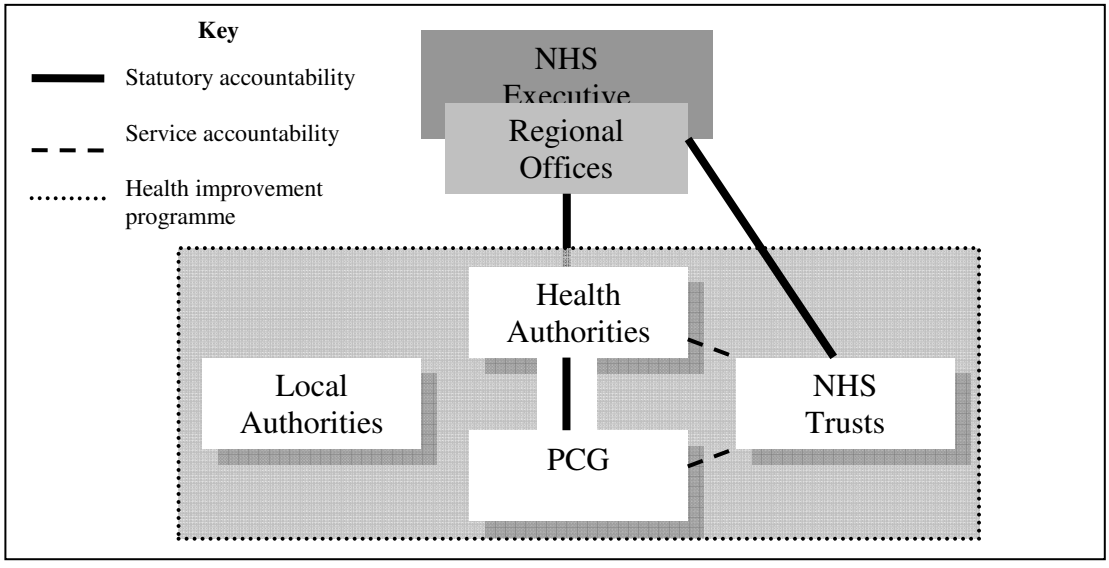
Source: Ham (2004)

The White Paper 'The New NHS' maintained the purchaser-provider split inherited from the Conservative government. However the GP fundholders were abolished and the function of purchasing carried out by the Health Authorities was

gradually transferred to primary care professionals (i.e. family doctors and community nurses) by means of the newly created Primary Care Groups (PCGs). The PCGs were groups of General Practitioners (GPs), in a given geographic area, which had devolved responsibility for managing a budget but were still under statutory accountability of the Health Authority. It was intended that the PCGs would evolve into free-standing Primary Care Trusts, with responsibility for commissioning hospital care and providing community health care for their population (Klein, 2006)

The objective of these structural changes was twofold. Firstly, to free up the Health Authorities to concentrate more on regional strategic issues, especially the development, in conjunction with the local authorities and NHS bodies, of the Health Improvement Programmes to serve as a instrument to translate national targets into practice (Ham, 2004). Secondly, to give primary care professionals more control over the allocation of resources and crystallize the idea of a primary-care-led NHS. Under this arrangement, PCGs were able to 'buy' hospital services for their local patients and, as a last resort, to switch between providers in order to establish better 'services agreements' in terms of efficiency and quality of services (Ibid). The new NHS structure that emerged from the White Paper is illustrated in the figure below.

Figure 4.2 The structure of the NHS from 1999



Source: Secretary of State for Health (1997)

The White Paper placed a strong emphasis on the performance of the healthcare providers, in terms of setting national standards, assessing and monitoring performances and introducing incentives (and sanctions) for health providers to achieve the national

standards. Contrary to the previous government, in which performance of healthcare providers was assessed mainly in terms of efficiency indicators, the White Paper proposed a wide range of performance criteria, including quality of clinical care, efficiency, patient satisfaction and access to healthcare. To help implement the new performance framework, two new organisations were set up, namely the Commission of Health Improvement and the National Institute for Clinical Excellence (NICE). The former was responsible for carrying out inspections and audits to evaluate the quality of clinical services in the health care providers. The latter was in charge of providing leadership on clinical and cost-effectiveness encompassing all parts of the health service (Secretary of State for Health, 1997).

Despite the government rhetoric of moving away from the 'old' Labour's 'stifling top down command and control', the government approach towards performance improvement of healthcare had in fact all the elements of a traditional command-and-control governance system. Rhetoric apart, the government approach to improve efficiency and quality of the NHS was the establishment of national standards and targets, backed up by threats of central intervention if the performance did not meet the expectations (Klein, 2006).

Into a crisis

Contrary to common expectation, the implementation of the White Paper neither attracted severe public criticism nor faced significant opposition from medical professionals or any other relevant interest group (Baggott, 2004). Indeed, even the cases of high-profile failure in the NHS that occurred during that period, such as the deaths of babies submitted to open-heart surgery in Hospital A, did not put the government in the line of fire. Quite the contrary, they had the effect of creating "a reservoir of public support for radical measures" and put potentially opposing groups, notably the medical profession, on the defensive (Klein, 2006).

This 'honeymoon' period, however, had come to an end by the beginning of 2000, not least because the government effort to bring down waiting-list had not produced the desired effect. Despite the injection of extra funds specifically to tackle the waiting-list problem, waiting-lists remained high (Klein, 2006; Baggott, 2004). As Klein (2006:202) points out:

> "But having nailed itself to the cross of reducing waiting-list, the Labour Government was in effect advertising the NHS's shortcomings. No matter that the lengths of the list were an ambiguous indicator of performance. No matter that they were, if anything, a misleading measure of the NHS's ability to meet demands. Waiting-lists were confirmed as the symbol of the NHS's inability to meet public expectations of quick and ready access to treatment. They represented rationing by delay."

Furthermore, a series of stories highlighting the NHS failure to provide quality services to patients started to frequent the news headline with more intensity (Klein, 2006). The case of patient Mrs Mavis Skeet, who had her operation for throat cancer cancelled several times until the point that it became inoperable, was emblematic of the NHS's inability to satisfy the demands of the patients. Throughout 1999, a general perception that the NHS was underfunded and failing to provide good quality services was apparent, subjecting the government to increasing pressure (Klein, 2006). This pressure over the government reached its apex in mid January 2000 after the interview of Lord Winston, a Labour peer and renowned doctor, who, drawing on his mother's personal experience in using the NHS, stated that the situation of the NHS was 'deeply unsatisfactory' (Baggott, 2004:122; Klein, 2006).

4.3 - The Alan Milburn Era (1999 – 2003)

The NHS Plan.

In October 1999, following Frank Dobson's resignation from the Department of Health to run for the London mayoral election, Alan Milburn, a young Labour MP reckoned to be ambitious and energetic, took over as the new Secretary of State for Health. Before his appointment, Milburn had worked as Chief secretary of the Treasury for 10 months after working as Minister of State of the Department of Health during the first 18 months of Blair's government.

Alan Milburn took office as Secretary of State for Health when the issue of the failure of the NHS in providing good quality services was coming to the fore (Klein, 2006). Just after the memorable interview of Lord Winston exposing his dissatisfaction

with the performance of the NHS, Tony Blair announced that the NHS funding would increase up to the average of the European countries over the next 5 years (ibid). Such increase, however, was not without its price. It had to be accompanied by measures that ensured more quality and efficiency in the delivery of the health services.

During his first months as Secretary of State for Health Alan Milburn devoted himself to elaborating the long-term government's strategy for improving the NHS. Six 'modernisation action teams' comprising representatives of key stakeholders were set up to identify the challenges facing the NHS and propose solutions. Alan Milburn wanted to encourage participation in the elaboration of the plan. As he put it: "Doctors, nurses and managers are to be key architects in drawing up a National Plan for the New NHS"[6]. The intention was to create a buy-in among professionals and "mobilize support for new ways of working within the services" (ibid).

The elaboration of the strategy for the NHS involved a long period of consultation and culminated in the publication of *The NHS Plan: a plan for investment, a plan for reform* in July 2000. The result of the consultation showed that the public attached high priority to 'more and better paid staff', 'reduced waiting times and high quality care centred on patients' and 'improvement in local hospitals and surgeries' (Secretary of State for Health, 2000). The causes of the NHS failure to meet the standards patient expected were attributed to the lack of sufficient funds over the past years; the lack of national standards and incentives to improve performance; over-centralization and disempowered patients; barriers between services and ineffective demarcation between staff (Ibid. p. 10).

To address the above mentioned problems, the Plan proposed a substantial increase in the NHS budget to fund growth in the NHS provider's capacity and facilities, including: 7,000 extra beds, over 100 new hospitals by 2010 and 500 new one-stop primary care centres, 7,500 more consultants and 2,000 more GPs, 20,000 extra nurses, 6,500 extra therapists and better hospital food, clean wards and modern IT systems (p.11).

Apart from the extra money to the NHS, the Plan's solution to the diagnosed problems seemed in many respects to rely more on an increase in the dosage of the same

[6] Quoted in Klein (2006:216)

existing ‘medicines’ than the prescription of ‘new medicines’. This is notable in the case of the command-and-control governance system introduced in 1997 to drive performance improvement in the health service providers. This command-and-control mechanism was retained and, in fact, strengthened in The NHS Plan (Klein, 2006). This strengthening came in the form of an expansion in the National Service Frameworks, establishment of top-down national targets and performance indicators to all hospital trusts as part of the Performance Assessment Framework, monitoring and annual publication of overall performance of the trusts, incentives for good performance (extra funds and ‘earned’ autonomy) and sanctions for poor performance (interventions and ‘franchising’ of the Trust).

However, a striking point of departure from the previous policies was an explicit recognition of the role of the private sector in helping to improve the capacity of the NHS. The NHS plan embraced the Private Finance Initiative, instituted during the Conservative government, which had been refuted by the Labour Party when in opposition (Klein, 2007; Baggott, 2004). Three further ‘themes’ in the NHS Plan introduced a new dynamic in the functioning of the NHS (Klein, 2006). First, A Modernisation Agency was set up to ‘spread best practices and stimulate change locally’ (p.60). Second, a strengthening in the patient protection net was introduced, including the creation of the National Clinical Assessment Authority to ‘provide a rapid and objective expert assessment of an individual doctor’s performance’ (p.90). Third, there was an attempt to give patients more influence and voice, through the determination that all trusts set up a Patient Advocacy and Liaison Service (PALS) and Patients’ Forum “provide direct input from patients into how local NHS services are run” (p.94).

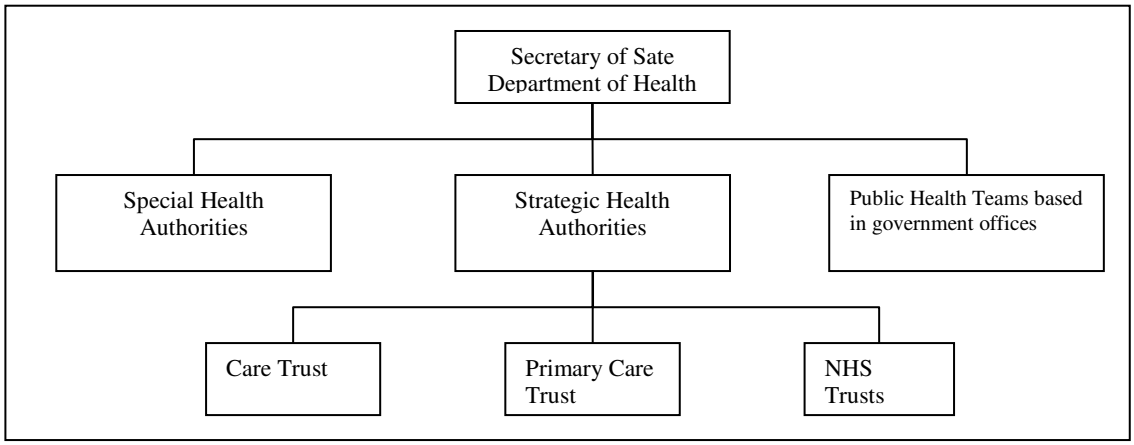
Despite the support received during its elaboration, the Plan was not without its criticisms. Baggott, (2004:124) identifies at least three aspects of the Plan that were subject to criticisms or controversies. Firstly, there was the over-centralisation of the structure, coupled with a substantial increase in the burden of regulations by a “plethora of bodies at national level regulating or overseeing health care”. Secondly, the targets were seen as too ambitious, raising scepticism on whether they were achievable. Finally, there was a concern that “public health was in effect being downgraded by the renewed emphasis on health services reforms.”

Shifting the Balance of Power

The NHS Plan had an effect more on the dynamic of the NHS bodies than on the structure of the NHS as whole. This period of relative structural stability did not last long. Another period of structural upheaval was heralded in the 2001 *Shifting the Balance of Power within the NHS* initiative. This initiative produced significant changes in the structure of the NHS, leaving untouched only the hospital trusts, and was regarded as the largest and least debated of the NHS for two decades (Smith *et al*, 2001).

The purpose of the reform was to give more power to front-line staff and patients in terms of decision and control over resources allocation (Department of Health, 2001). In the core of the changes introduced during this initiative was the reduction of the number of health authorities from 95 to 28, which came to be named Strategic Health Authorities; the creation of Primary Care Trusts to take on a great part of the responsibility of the health authorities over commissioning and planning of health services; and the abolishment of the Regional Officers of the Department of Health. In lieu of the Regional Officers, four new Regional Directors of Health and Social Care were set up to "oversee the development of the NHS and provide the link between NHS organisations and the central department" (p. 6). The new structure of the NHS after this reform can be illustrated in the figure below.

Figure 4.3. The structure of the NHS after 2002



Source: Ham (2004)

Delivering the NHS Plan.

In April 2002 the government published the White Paper '*Delivering the NHS Plan*' (Secretary of State for Health, 2002), which set out a series of propositions that would turn out to be the pillars of a set of succeeding reform programmes that took place over the following years. The White Paper focussed on the "reform of the supply side system design" (p.4), by proposing an increase in the use of private providers, including international providers, to "expand choice and promote diversity in supply" (p.5).

Such a promotion of diversity of service providers should be accompanied, the White Paper stated, by the introduction of explicit patient choice on referrals of any provider, be it a public hospital (local or elsewhere), private hospital, hospital overseas, or any other kind of treatment or diagnostic centre. The paper's intention was that by 2005 all patients and their GP would "be able to book appointments at both a time and a place that is convenient to the patient" (p.5).

To support the movement of patients across service providers the White Paper introduced a switch of the hospital payment system to 'payment by results'. The main thrust of this new system was that 'money follows patients'. The intention was not only to create a fairer payment system, in the sense that the hospitals are remunerated according to the number of patients they treat. It also intended to introduce an incentive mechanism "to reward good performance, to support sustainable reductions in waiting times for patients and to make the best use of available capacity" (p.20). This incentive mechanism, the Paper maintained, would replace the hitherto perverse incentive system by which "hospitals that are doing well in getting waiting times down are often forced not to use their spare capacity to treat more patients because that breaks through the budget ceilings they have been set, [and] poorer performers in the NHS are often bailed out with extra financial help" (p.19).

Another important element of the White Paper was the decision to identify the first highly performing NHS hospital trusts that would be transformed into NHS Foundation Trusts (p.5). Those trusts that became foundation trusts would have more freedom and autonomy from the Department of Health to manage their services and

greater involvement of, and accountability to, local community. The establishment of Foundation Trusts was the mechanism the government found to implement its intention to move away from the command-and-control system and establish a devolved NHS. Although such a flexibility and autonomy later proved to be more circumscribed than the government had desired, the Foundation Trust was considered "potentially the most radical organisational innovation in the history of the NHS since its inception" (Ham, 2004:66).

The White Paper introduced a series of other measures that had an impact on the dynamics of healthcare provision. It reinforced the policy of devolution to frontline staff and patient by expanding the control of NHS budget by Primary Care Trusts to over 75%. Some national targets, against which the performance of PCTs and hospital trusts was assessed, became tougher to follow an increase in the 2002 budget. The waiting time target for operations, for instance, was announced "to fall from a maximum of 15 months now to 6 months by 2005, and 3 months by 2008" (p.4). Finally, the White Paper proposed the creation of a new tough independent healthcare regulator/inspectorate, The Commission for Healthcare Audit and Inspection (which was later created with the name of 'Healthcare Commission'), to "bring together the health value for money work of the Audit Commission, the work of the Commission for Health Improvement and the private healthcare role of the National Care Standards Commission" (p.38).

The creation of a single new healthcare regulator to carry out the activities previously developed by three distinct bodies was the fruit of the government's explicit recognition of the inconvenient burden of regulation that a fragmented web of regulatory bodies imposed on the services providers. As stated in the White Paper: "Whilst each has made an important contribution to improving standards, the same local NHS organisation can face multiple uncoordinated visits and demands" (p.38). Another reason, though not explicitly stated in the White Paper, was the recognition by the government that their centralized command-and-control system led anyone but the central government to respond to performance failure of frontline services providers (Ham, 2004). Devolution of responsibility as much as possible, accompanied by a strong regulation, was thought of as a plausible solution for this problem. Therefore, "strengthening the role of inspectors and placing more emphasis on regulation were a logical consequence of these developments" (ibid: 69).

Although the governmental rhetoric had been hostile to the idea of 'internal market', the White Paper heralded a phase in the NHS evolution which has been considered as the recreation of the 'internal market', though in a more sophisticated version (Ham, 2004, Klein, 2006). Klein (2006: 218) highlights three elements of the White Paper that characterise the internal market, namely the patient choices for any healthcare providers; the money following the patient ('payment by results'); and the increased competition brought about by the increased diversity of providers.

4.4 The John Reid Era (2003 – 2005)

The NHS Improvement Plan

In June 2003, following the unexpected resignation of Alan Milburn, John Reid was appointed the new Secretary of State for Health. John Reid entered office having to face an immediate impasse between the government and the consultants, who were threatening industrial action in relation to their contracts (Dyer, 2003). At the same time, the NHS started to face a multitude of pressures from diverse fronts: the central government had been accused of over-centralized micro-management (Timmins, 2002; Ham, 2004:69); the idea of foundation trusts became contentious (Klein, 2006); the government was accused of acting recklessly in relation to the changes in the patient's complaints procedures (Eaton, 2003) and some 'perverse' effect of the 'targets' governance system came to the fore (House of Commons Public Administration Select Committee, 2003). On the positive side, the effort to reduce waiting times started to take effect[7]. The maximum waiting time for operations fell from 18 months, in 1997, to less than nine months and the maximum waiting time for outpatients fell from 26 weeks to 17 weeks in the same period (Secretary of State for Health, 2004).

It is against this background that the government launched in June 2004 the White Paper 'The NHS Improvement Plan' (ibid), setting out a series of measures for reforming the NHS. The document started by celebrating the achievements in waiting lists and the increase in the NHS resources (more staff and budget). The White Paper went on to set out a multitude of measures for the NHS, most of them elaborated on the previous plans. However, three features of the proposal gave a distinct character to the

[7] Geoffrey Rivett.http://www.nhshistory.tryfan-online.co.uk/index.html. Accessed in 04 March 2008.

White Paper: a stronger emphasis on patient choice; a more elaborated implementation of the payment by results; and a reform of the regulatory and performance measurement system.

Improving patient choice was uppermost in John Reid's mind. He stated his vision of the NHS as follows: "An NHS which is fair to all of us and personal to each of us by offering everyone the same access to, and the power to choose from, a wide range of services of high quality, based on clinical need, not ability to pay." (Secretary of State for Health, 2004: 6). The White Paper provided a step forward in the government intention to make patients call the shots in relation to the time and place of their care. "Patients' desire for high-quality personalised care will drive the new system", the document stated (p.9). The White Paper went on to announce that "from the end of 2005, patients will have the right to choose from at least four to five different healthcare providers [and,] in 2008, patients will have the right to choose from any provider, as long as they meet clear NHS standards and are able to do so within the national maximum price that the NHS will pay for the treatment that patients need" (p.9). To increase the diversity of choice for patients, the White Paper stated that, by 2008, independent sector providers will provide up to 15% of procedures on behalf of the NHS. The structure of the NHS which emerged from this reform can be depicted in figure 4.4.

The NHS Improvement Plan reform also gave a step further in the elaboration of the proposal of 'payment by results' already underway. As described in the previous section, in the 'payment by result' system the money would follow the patient. The intention behind this new payment system was to introduce the incentives for services providers to treat more patients, thereby fostering competition among providers. Central to the operation of 'payment by results' was the elaboration of a cost system, in which tariffs for individual services were nationally calculated reflecting the complexity of the services. Patients would, by 2008, be able to "choose any provider able to meet NHS standards and to deliver care at tariff" (p.70). The government intended 'payment by results' based on national tariffs would "stimulate greater efficiency as providers take action to bring their costs into line with the tariff, for example by reducing lengths of stay in hospital" (p.70).

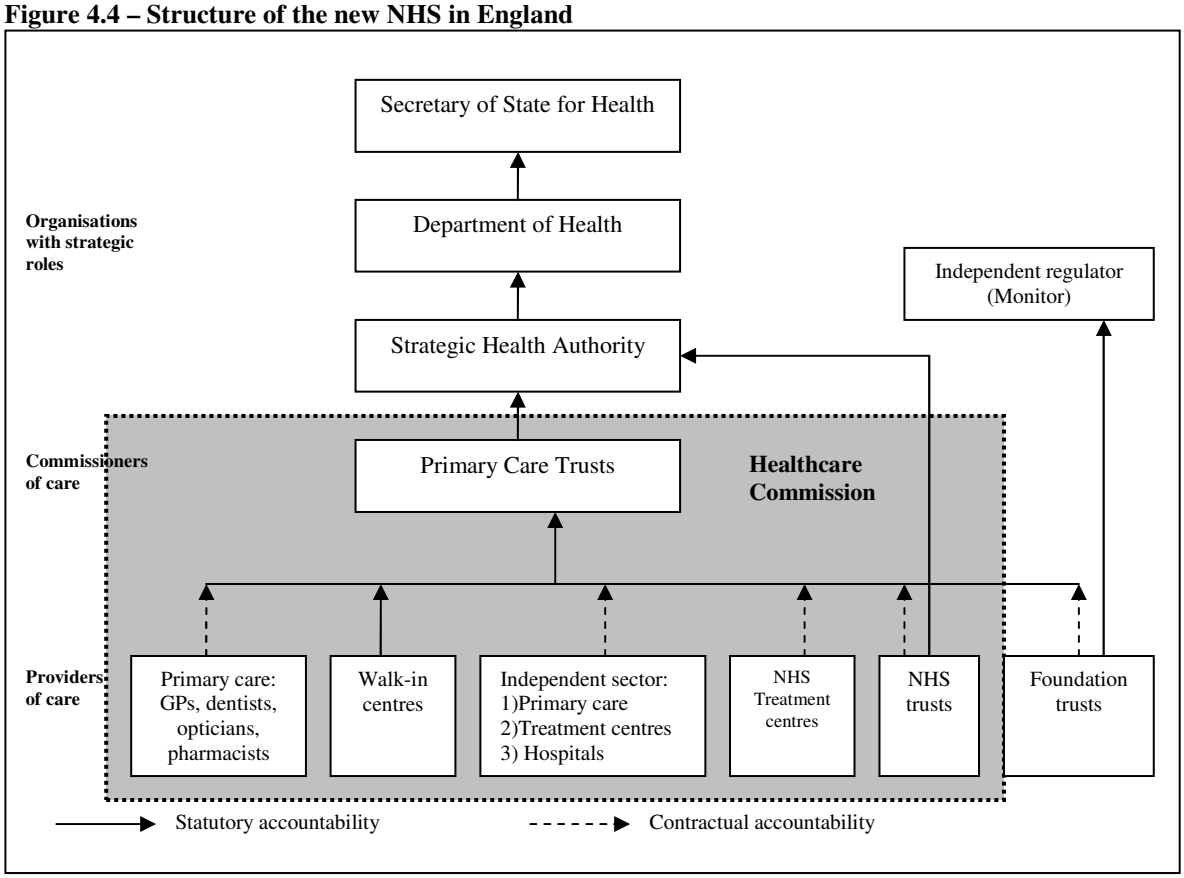
As for the regulatory apparatus and performance measurement framework, the White Paper heralded a period of great transformation in the performance regulation in the way central government assessed performance of frontline providers. In response to the outcry against the explosion of regulation, and the associated burdens and overlaps, the creation of the Healthcare Commission started to take shape. This solution is in line with what Klein (2006: 231) describes as "rationalisation through amalgamation", in which the Healthcare Commission emerged as a sort of "all-embracing regulatory body". Working independently of the Department of Health, the Healthcare Commission would be responsible for monitoring and reporting "on the quality of commissioning and services across the NHS and, increasingly, the private sector" (Secretary of State for Health, 2004:76). An exception was made in the case of the Foundation Trusts, which would be solely accountable and regulated by a non-departmental public body established in 2004. This organisation, named Monitor, was responsible for authorising "the establishment of and then regulate the corporate conduct of NHS Foundation Trusts, including the enforcement of any sanctions resulting from non-compliance with national standards" (ibid).

In parallel with the creation of the Healthcare Commission, the White Paper introduced a radical change in the way the performance of the services providers had been assessed. To respond to the criticisms about the adverse effect of assessing the overall performance by means of a set of 'targets', the White Paper set out the lines of a new evaluation approach that put more emphasis on achieving 'national standard' and less on achieving targets (Klein, 2006). Following a consultation exercise launched in February 2004, the government published a set of standards, against which the performance of the healthcare providers would be assessed (Department of Health, 2004). Rather than having their performance assessed mainly against the achievement of national targets, most of them based on waiting times, healthcare providers were expected to meet a set of standards, which included "safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities and public health" (p.8). The Healthcare Commission was made responsible for applying the standards to "assess the quality of NHS healthcare and to support improvements in care" (Secretary of State for Health, 2002:22).

The new performance assessment approach evolved into the 'annual health check', which replaced the previous 'star rating' system. Under the 'annual health

check' the quality of the services of the providers came to be evaluated on the basis of the achievement of a comprehensive series of national standards and targets. To lighten the regulatory burden and optimize its activities, the Healthcare Commission adopted a risk-based and light-handed approach to its work (Klein, 2006). The collection of data for evaluation was based on a system of self-assessment by trusts and by which only 20 per cent of the trust were to be visited: "a random sample of 10 percent and a further 20 percent where there was reason for concern" (ibid, 231).

Figure 4.4 – Structure of the new NHS in England



Adapted from Talbot-Smith and Pollock (2006).

4.5 - The Patricia Hewitt Era (2005 – 2007)

Build the Momentum of Reform.

In May 2005, following the general election won by the Labour Party, John Reid was appointed Secretary of Defence and Patricia Hewitt, the then Secretary of Sate for Trade and Industry, took over as the new Secretary of State for Health. In December of the same year, Patricia Hewitt launched the document 'Health Reform in England: update and next steps' (Department of Health, 2005), which provided an overview of

the developments in the NHS and set forth the 'next steps' for reform. Most of the proposed reforms elaborated on policies that were already underway. The idea was to make of the NHS a 'self-improving' organisation, with an "in-built dynamic for continuous improvement…to enable the NHS to keep pace with fast-changing technology, to tackle inequalities and to raise standards of care" (p.2).

Patricia Hewitt's policy for achieving the 'self-improving' NHS rested on four pillars: more choice and stronger voice for patients; more diversity of providers with more freedom to innovate and improve services; money following the patients; and "a system of management and decision making to support quality, safety, fairness, equity and value for money" (p.3). Most of these policies were not really new. It was the intention of the document to "build the momentum of reform" between 2005 and 2008, by further developing and implementing the new incentives (patient choice, payment-by-results, diversity of providers and more autonomy to providers) and a revised management and regulatory framework (p.3).

New Directions for Community Services

Patricia Hewitt's own polices for the NHS came to be published in January 2006, in the White Paper 'Our health, our care, our say: a new direction for community services' (Secretary of State for Health, 2006). Building on the tripod patient choice, payment-by-result and diversity of providers, the White Paper aimed to achieve four goals: greater emphasis on prevention; more choices and 'louder' voices to patients; more integration between local health and social care commissions in tackling inequality; and more support for people with long-term conditions. Central to her proposal, however, was the intention to "shift resources into prevention" (p.9) and the "resurrection" of the concept of 'GP fundholding,' now under the label of 'practice-based commissioning' (Klein, 2006:233).

The White Paper intended to improve the health of the population by providing greater emphasis on prevention and early interventions. The idea was to shift 'the centre of gravity of spending', from interventions to prevention. "We want our hospitals to excel at the services only they can provide, while more services and support are brought closer to where people need it most", the White Paper stated (Secretary of State for Health, 2006: 9). The idea to shift the resources to prevention was grounded on the assumption that "preventative measures involving a range of local authority services,

such as housing, transport, leisure and community safety, in addition to social care, can achieve significant improvements in well-being" (p.46). The White Paper then went on to announce a series of measures aimed at providing integrated health and social care and fostering a healthy lifestyle, ranging from the creation of the 'NHS Life Check' (a sort of life-style risks assessment tool) and the promotion of leisure/sports areas for the population.

An important, and contentious, element of the White Paper was the change in health services commissioning by introducing the idea of 'practice-based commissioning.' This idea was hardly new. It had already been launched in October 2004 (Department of Health, 2004b), but gained traction in the 'Our health, our care, our say' reform. Under the practice-based commissioning all GPs would receive an indicative budget for commissioning secondary health services and, within that budget, would "be able to free up money to do more for people with long-term conditions and other priority needs" (p.165). Practice-based commissioning, the White Paper argued, will "provide incentives to avoid unnecessary stays in hospitals…and enable [GPs] to devote more resources to more cost-effective prevention, including social care" (ibid). The intention was to put the budget in the hands of those who, in practice, determine the use of the healthcare. By having responsibility over the budget GPs would "have a direct incentive to limit patient demands or to substitute less expensive interventions for high-cost hospital procedure – so supporting another government goal, that of moving an increasing proportion of services into the community" (Klein, 2006: 233).

Into a Crisis – Again.

In the beginning of 2006, just when the government was ready to celebrate further achievements of its continuous plans - waiting lists were dropping and quality had improved, – the NHS was lurching to a crisis: "NHS trade unions staged protests as staff were laid off; patients worried as media stories about hospitals delaying treatment or economizing on drugs multiplied, the Chief Executive of the NHS took early retirement; and the Prime Minister rushed to the defence of the government's policies" (Klein, 2006b:409). By March 2006 the NHS was heading for a financial deficit of approximately £ 500 million (Department of Health, 2006b). Although such a deficit represented only 0.8 percent of the revenue resources available to the NHS, it led the government to pressure overspending healthcare providers for retrenchment, thereby

triggering a series of hostile criticisms and scepticism against the government's policies (Klein, 2006b).

It seemed the public patience for the continuous oscillation of policies and changes over the almost one decade of New Labour's government had come to an end. In the annual meeting of the British Medical Association in June of 2006, doctors severely blamed the government's "perpetual reorganisation and 'relentless ideological reforms" for the financial 'crisis' of the NHS. The doctors maintained that the government 'has taken a record of money away from the care of patients and "squandered" it on unproved reforms' (Kmietowicz, 2006). The meeting ended with the approval by its members of a motion urging for an "active opposition and proper scrutiny" against the government's policies (Ferriman, 2006). The BMA took this proposition seriously and, in the months that followed, put forward a proposition for the creation of an independent board of governors to run the NHS in England and, hence, "take politics out of the NHS" (Kmietowicz, 2007).

The period of Patricia Hewitt as Secretary of State for Health was, therefore, characterized by fierce opposition from the BMA against government's policies for the NHS. The Chairman of the BMA expressed his view of her policies in an interview to The Guardian as follows: "the policies of Patricia Hewitt, the health secretary, were incoherent and contradictory, and were serving to fragment services among competing providers instead of encouraging collaboration to meet the full range of patients' medical needs"[8]. In June 2007, following the resignation of Tony Blair as Prime Minister, Patricia Hewitt left, ending the era of continuous reforms in the NHS under Tony Blair's mandate.

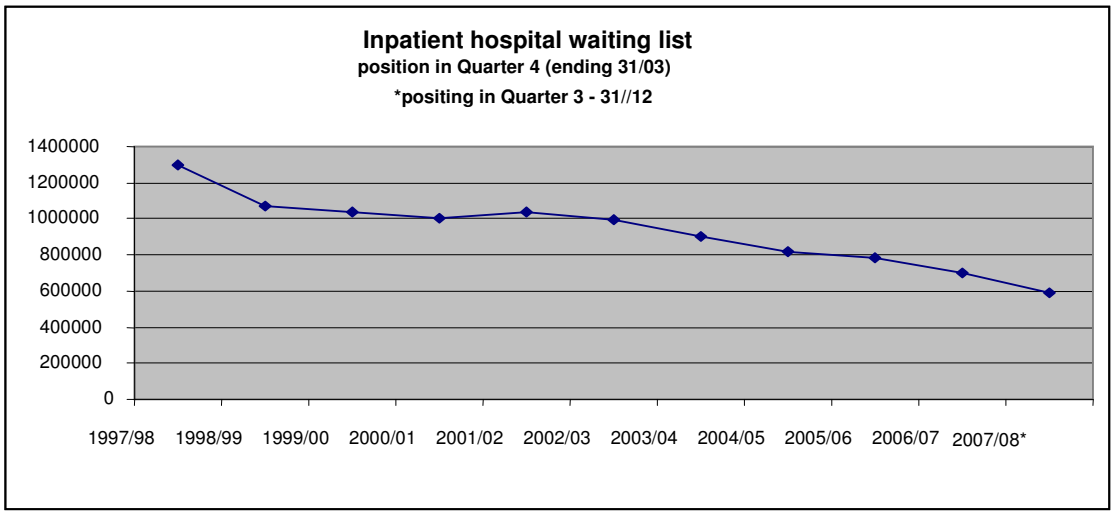
4.6 – The Impact of the Reforms on the Services Providers

The literature on health policy in Britain is replete with studies and official reports offering an assessment of the impact of the policies implemented over Tony Blair's mandate. At least as far as the key targets and indicators used by government are concerned, these studies demonstrate that the results achieved were significant: the waiting list for inpatient treatment has dropped from approximately 1,3 million in March 1998 to approximately 590,000 in December 2007. Similarly, whereas in March

[8] John Carvel in *The Guardian*, Wednesday May 9 2007.

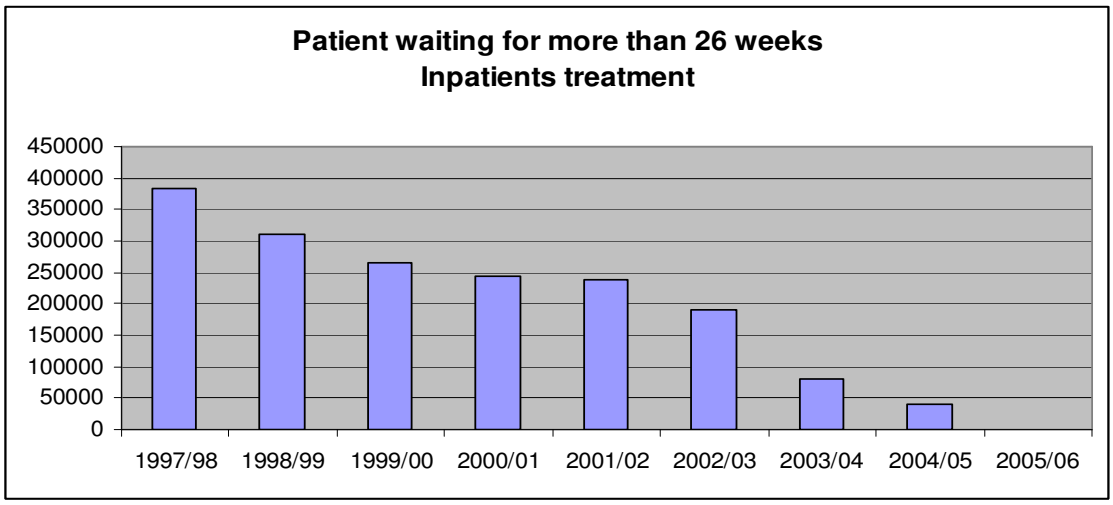
1998 more 380,000 patients waited more than 26 weeks for hospital inpatient treatment, in March 2006 only 206 patients were reported waiting this time (see charts below). The comparison of England's indicators with the other UK countries that did not adopt the same policies, particularly the performance governance system, also demonstrated the notable improvements achieved by the government's policies. This list demonstrating positive results, especially against the targets and key performance indicators, can be extended (see Le Grand, 2006; Klein, 2006b; Department of Health, 2006; Bevan and Hood, 2006 and Leatherman and Sutherland, 2003).

Figure 4.5 – Evolution of Inpatient waiting list



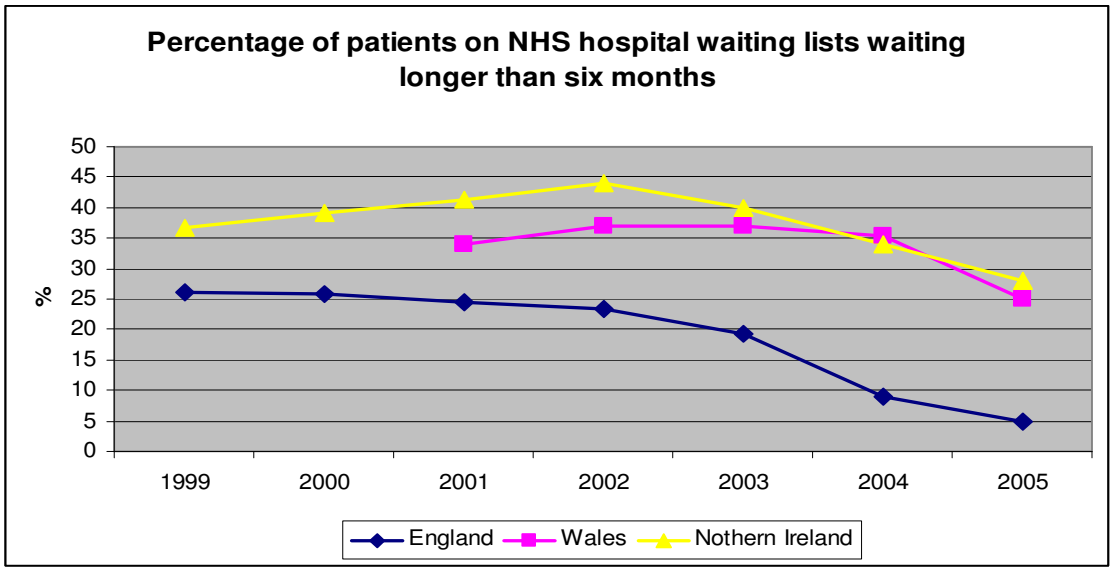
Source: Department of Health – Waiting Times Statistics: www.performance.doh.gov.uk/waitingtimes

Figure 4.6 – Patient waiting for more than 26 weeks for inpatient treatment 1997 to 2006



Source: Department of Health – Waiting Times Statistics: www.performance.doh.gov.uk/waitingtimes

Figure 4.7 – waiting times in UK countries



Source: Bevan and Hood (2006a)

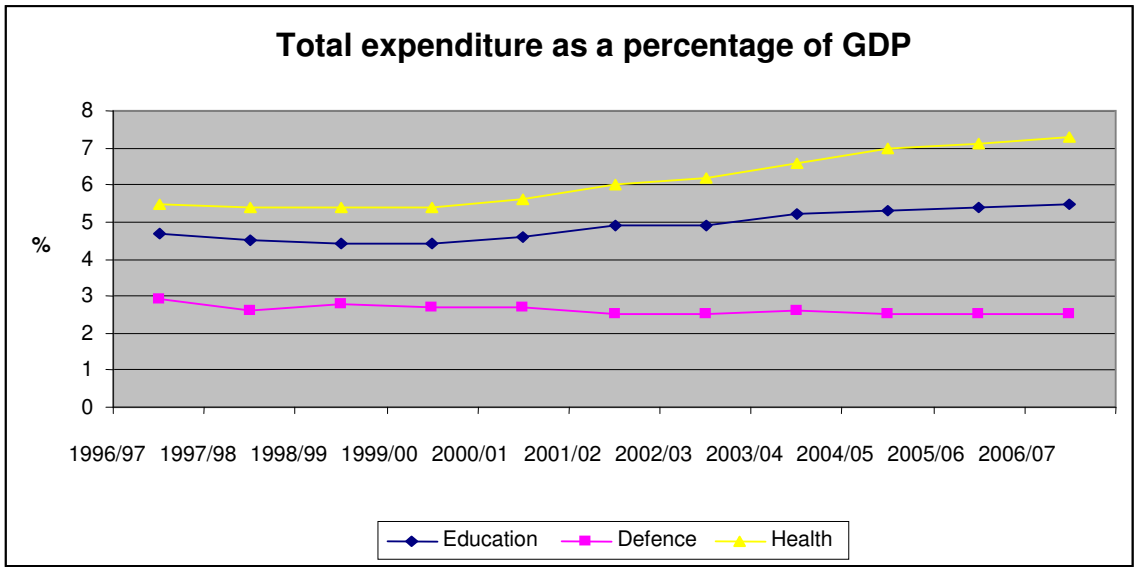
However, a more accurate and comprehensive evaluation of these policies in terms of their effectiveness and impact on the health of the population involves a much more complex and sophisticated analysis, which is beyond the scope of this research. Rather, for the purpose of this research we are more interested in the impact of this policy context on front line organisations, in particular the NHS hospital trusts. This policy context analysed throughout this section represents the characteristics of the 'task' environment within which NHS hospital trusts are immersed.

An established way to analyse the effect of the task environment on organisations is to examine its munificence, complexity and dynamisms (Dess and Beard, 1984). Although these dimensions were drawn from literature on private sector organisations, they also apply to the case of public organisations (Rainey, 1997).

Munificence refers to the availability of resources in the environment (Rainey, 1997). Changes in munificence of the environment have been operationalised in terms of change in availability of financial resources to organisations (Boyne and Meier, 2009). In the case of hospital trusts in England, the change in munificence of the environment can be measured in terms of the growth of governmental expenditure on health. In this sense, it is safe to argue that the ten-year period under analysis (1997 – 2007) was characterised by an unprecedented increase in environmental munificence. Following the announcement of Tony Blair in January 2000, during the first crisis examined during this period, government expenditure on health experienced a

substantial increase in the rate of growth, from 5.5 in 1999/00 financial year to 7.3 in 2006/2007 financial year (see chart below). In absolute terms, these numbers represent an increase in spending from £ 57.3 billion to £ 92.8 billion, in real terms.

Figure 4.8 – evolution of health expenditure in UK as percentage of GDP



Source: HM Treasury – Public Expenditure Statistics - 2007

Dynamism refers to the pace of changes in important components of the environment (Aldrich, 1979). The analysis carried out in this section demonstrated that the environment of the NHS trusts in UK under the period of 1997 to 2007 was anything but static. There were five changes in Secretary of State for Health, each accompanied by changes in priorities and new direction for reform. These changes took place in various aspects. To recall just some examples, this period witnessed the following changes: from the 'stars rating' to the 'annual health check'; from GPs fundholdings to Primary-care-led commission to GPs fundholding again under the new guise of practice-based-commission; not to mention the 'death' and 'resurrection' of the internal market over this period. In discussing the impact of the pace of the changes in policies during the 10-year Blair government on the political crisis taking place in the end of his mandate, Klein (2006b:412) points out that "The oscillations of policy over the past decade have severely tested the capacity of NHS managers to absorb and adapt to change; medical morale remains brittle, as doctors see their status and autonomy threatened by a regime of inspection and regulation. Managers and professionals alike see themselves as victims of ministers in a hurry, having to take the blame for the government's miscalculations."

The complexity of the environment involves the "number of different external components and characteristics an organization must deal with" (Rainey, 1987, citing Miles, 1980). During the period under analysis the complexity of the environment is represented in terms of the increase in the number of diverse sorts of regulatory organisations and the introduction of competition in the NHS environment. As for regulatory arrangements, the changes in Secretary of States for Health had often been accompanied by the creation or 'amalgamation' of organisations to regulate certain aspects of the new policies being introduced. Walshe (2003: 153) highlights the complexity of the regulatory web that was involved in the operation of NHS trusts during the period of analysis (see figure 2.1 chapter 2). By analysing the impact of the performance governance system introduced in England during this period, Bevan and Hood (2006b) assert that "what lay behind the system of governance by targets in health care in the early 2000s amounted to an institutionally complex and frequently changing set of overseers, inspectors and assessors".

A striking aspect of the regulation of the NHS was the introduction of a sophisticated performance governance system, in which central government sought to improve the performance of the healthcare providers by setting 'targets' coupled with a set of incentives to meet them. Among the incentives (and sanctions) was the possibility of a direct intervention of central government to replace the CEO or even the whole management team; "shame or glory accruing to managers on the basis of their reported performance" (Bevan and Hood, 2006b:519) and an 'earned autonomy' for high performing organisations. This combination of 'target' with a 'threat' of sacking managers as a result of poor performance comprises what has been called a 'target-and-terror' performance governance system (ibid).

The literature is replete with examples of the 'perverse' effect of the 'target-and-terror' governance system introduced in the NHS during this period. The most cited are 'gaming' and the effect on managers' morale. Gaming refers to a "reactive subversion such as 'hitting the target and missing the point' or reducing performance where targets do not apply." (Bevan and Hood, 2006b:521). Although there is no measure of the widespread use of this practice, evidence suggests the occurring of at least three types of gaming among NHS healthcare providers: hitting the targets at the expense of poor performance in non-measured areas; 'hitting the targets and missing the point' and

'fabrication of data' (Bevan and Hood, 2006). Examples of the occurrence of these kinds of gaming are shown in the table below.

Table 4.1. Evidence of gaming in the NHS in response to three types of targets

	Target		
Problem	**<4 hour wait in accident and emergency**	**Ambulance category A calls**	**Maximum waiting times for first elective Hospital Bdmission**
Poor performance in domains where performance were not measured	Extra staff drafted in and operations cancelled for the period over which performance was measured	Strong allegations that some ambulance trusts relocated depots from rural to urban areas hence achieving the target at the expense of a worse service in rural areas	
Hitting the target and missing the point	Patients had to wait in ambulances outside the department until staff were confident of meeting the target.	Idiosyncrasies in the rules of classification led to some patients in urgent need being given a lower priority than less serious cases	Patients may have been removed from waiting lists once they had been provided with a future date for an appointment, or given immediate appointments that they were not able to attend and then classed as refusing treatment, or had treatment inappropriately suspended
Ambiguity in reporting of data or fabrication	The level reported to the Department of Health in 2004-5 was 96%, but an independent survey of patients reported only 77%	Problems in the definition of category A calls (the proportion of logged calls varied by more than fivefold) and ambiguity in the time when the clock started. A third of ambulance trusts had "corrected" response times to be less than 8 min	Nine NHS trusts had "inappropriately" adjusted their waiting lists; three others had deliberately misreported waiting list information; and 19 trusts had reporting errors in at least one indicator

Source: Bevan and Hood (2006a)

As for the effect on the morale of managers, the 'target-and-terror' system introduced a high sense of insecurity among chief executives. Under this target regime, healthcare managers were "exposed to increased risk of being sacked as a result of poor performance on measured indices" (Bevan and Hoodb, 2006: 518). Indeed, the period under analysis witnessed a high level of chief executives and top managers' turnover. The average annual CEO turnover rate from 1998 to 2005 was approximately 20 percent, with a peak of 25.6 percent in 2002 (Ballantine *et al,* 2008). As we shall see in the next chapter, one organisation used as a case study had 7 CEOs from 2000 to 2007. Therefore, for this period, "running a NHS trust had become a high-risk occupation" (Klein, 2006:225).

Another component of the 'complexity' dimension of the environment was the 'resurrection', now in a more sophisticated version, of the internal market and the competition it brought along. The competition was fostered due to the combination of three elements introduced during the second half of Tony Blair's period: patient choice; payment-by-results (i.e. money following patients) and diversity of healthcare providers

(including oversees and private providers). The introduction of more complexity in the environment, in terms of competition and number of stakeholders, had the effect of demanding more strategic activities by the organisations (c.f. Aldrich, 1979).

4.7 - Concluding Remarks

In this chapter we described the changes in policies and structure of the NHS since 1997, when New Labour won the election, to 2007 when Tony Blair resigned as the prime minister. Although there were a multitude of policies and initiatives during this period, it is possible to identify some pattern of changes: a historically unprecedented increase in finance (capacity), followed by a centralised strong command-and-control approach to drive performance improvement and, later, a shift towards more decentralized management with strong ingredients of market competition. Klein (2006:219) sees these "tectonic" changes as an example of a typical "policy learning", in which policy-makers responded "to a variety of pressures and learning with their mistakes". Indeed, when confronted in an interview with a question about his change in opinion about the use of the private sector, Alan Milburn said, "you live and you learn in politics, or you should—point one. Point two, I think there's a narrative to what has happened since Labour came into office[9]".

The characteristic of the policy context of the NHS during this period, which could potentially affect the operations of NHS trusts, was analysed in terms of three dimensions: munificence, dynamisms and complexity. It was demonstrated that during this period there was an increase in munificence, brought about by an unprecedented level of government expenditure on health. The high pace of change in policies, initiatives and priorities, often preceded by a change in command of the Department of Health, bears all the hallmarks of a highly dynamic environment. The complex web of organisations that have some sort of influence over the NHS trusts, a tough performance management system, and the introduction of competition among NHS healthcare providers, increased the level of complexity of the NHS environment.

Empirical studies have shown that all these attributes of the environment have an impact on organisation 'decline' and turnaround, whether creating opportunity or 'challenges' (Boyne and Meier, 2009; Andrews *et al*, 2006). Organisations respond

[9] Timmins (2002).

differently to the pressure and opportunities from the environment. In the case of the NHS during the period under analysis, a number of organisations were able to cope with this demanding environment and even improve their performance. Conversely, a considerable number of organisations regarded as a 'failing' organisation in the beginning of the 2000s are still struggling to improve their performance. This leads to the following questions: why were some low performing organisations able to improve their performance and sustain it as a continuous process, while others, facing a similar task environment, had not had the same fate? More precisely, what are the organisational and managerial capabilities, whose lack or absence caused hospital trusts to lower their performance level, and whose development and use caused them to increase it and sustain that performance improvement? In the following chapters I explore these questions by highlighting the differences in the use of organisational and managerial capabilities between a trust which has gained performance and a trust which is still struggling with the recovery and renewal process.

Chapter 5 - Case Study 1: Hospital A[10]

5.1 - Background and history of the trust

The Hospital A was formed in April 1991, following the first wave of trusts introduced under the new purchaser-provider arrangement made during the Conservative government's '*Working for Patients'* reform. The main function of the Trust was to provide secondary healthcare by owning and managing Hospital accommodation and services at eight premises in the centre of the city[11].

The transition to the purchase-provider split involved approximately two years of preparation before the hospitals that formed Hospital A Provider Unit - BPU (the precursor, or 'shadow' form of HOSPITAL A) received the trust status[12]. An important aspect of this preparation was the organisation of the BPU structure in the form of twelve clinical directorates, each managed by a clinical director and a general manager. This directorates' arrangement resonated with the "prevailing thinking of the day about appropriate ways of managing healthcare" and of delivering on the Griffiths Report[13]. The original idea underlying the clinical directorates' structure was to combine budgetary responsibility and clinical decision making within a single unit."[14]

Once in operation, the HOSPITAL A maintained the clinical units grouped along the same lines created by its precursor, 'shadow' organisation. Some clinical directorates had their function altered and another directorate was added to the group, making thirteen directorates in all. The management of the Trust was the responsibility of the newly appointed board, which comprised a chairman, five non-executive and five executive directors, including the Chief Executive Officer.

Dr. Peter Rowland[15], the former district general manager of The city of Hospital A and Weston Health Authority, was appointed the first CEO of the Trust. From the

[10] All names used in this case are pseudonym
[11] The Report of the Public Inquiry into children's heart surgery at the Hospital A 1984-1995 '**Learning from Hospital A'**, by Ian Kennedy, 2001. Popularly know as "The Kennedy Report"
[12] The Kennedy Report
[13] Smith and Ham (2000)
[14] Ibid.

very beginning, Dr. Peter Rowland took the view that authority should be delegated as far as possible to the clinical directorates, 'confirming the directorates as the core units of management in the trust'[16]. The directorate arrangements evolved into a devolved management system with considerable decisional power in the hands of consultants, thereby leaving managers a more peripheral role of managing the facilities for the exercise of clinical activities:[17]

> "Dr Rowland believed that healthcare in the hospital was: 'led by consultants', and that they were 'self-teaching' and 'self-correcting'. Dr Rowland said that it was 'impossible' for managers to interfere. It was 'a fact' that only clinicians could identify defects in the performance of other clinicians. He saw the role of management as being: 'to provide and co-ordinate the facilities which would allow the consultants to exercise clinical freedom… Dr Rowland's management philosophy attached importance to: 'management by values and not by objectives''[18]

In October 1995, Dr. Peter Rowland left and Paul Morris took over as the trust's new CEO. Once in office, Paul Morris realized that the excessively devolved management arrangement made it difficult to exercise a more effective control of the Trust's performance: "I did feel, when I came to the Trust, that the devolution to the directorates had gone too far and that the overall performance of the organisation was not as tightly controlled and managed as it needed to be...There were not sufficient mechanisms and information systems in place for me to assure myself that all of the directorates were operating in a proper manner."[19]

Around this period some failures of a major hospital of the Trust, in carrying out open-heart operation in children with congenital cardiac disease, resulting in the death of children submitted to this surgical intervention, came to the fore[20]. Formal complaints were made to the General Medical Council concerning the death of children submitted to this medical intervention, which, in 1998 resulted in two surgeon and the former CEO be found guilty of professional misconduct[21]. 'A group of parents of

[16] Smith and Ham (2000)
[17] The Kennedy Report.
[18] Ibid
[19] Statement of 'Paul Morris' to the "Kennedy Inquiry", The Kennedy Report.
[20] The Kennedy Report
[21] Ibid

children who had undergone cardiac surgery at the HOSPITAL A, organised themselves to provide mutual support. In June 1996 the group first called for a Public Inquiry into the paediatric cardiac surgery services at the HOSPITAL A. On 18 June 1998 Frank Dobson MP, then Secretary of State for Health, announced to Parliament the establishment of this Inquiry'[22], which turned out to be popularly know as 'The Kennedy Inquiry.'

The main purpose of the inquiry was "to inquire into the management of the care of children receiving complex cardiac surgical services at the Hospital A between 1984 and 1995 and relevant related issues."[23] During that period approximately 35 children who had been submitted to open-heart surgery from 1991 to 1995 died. The death rate for that specialist operation at HOSPITAL A was considered twice as high as elsewhere[24]. The Inquiry was conducted between October 1998 and July 2001, and consumed a considerable amount of time and attention of the Trust's staff, and brought great deal of negative publicity to the Trust and the NHS more generally.

The end of the decade and the beginning of the 2000's witnessed a trust where top managers and key clinicians were heavily immersed in satisfying the demands of the Kennedy Inquiry and dealing with its effect. As a member of the Trust Board in that period recalled:

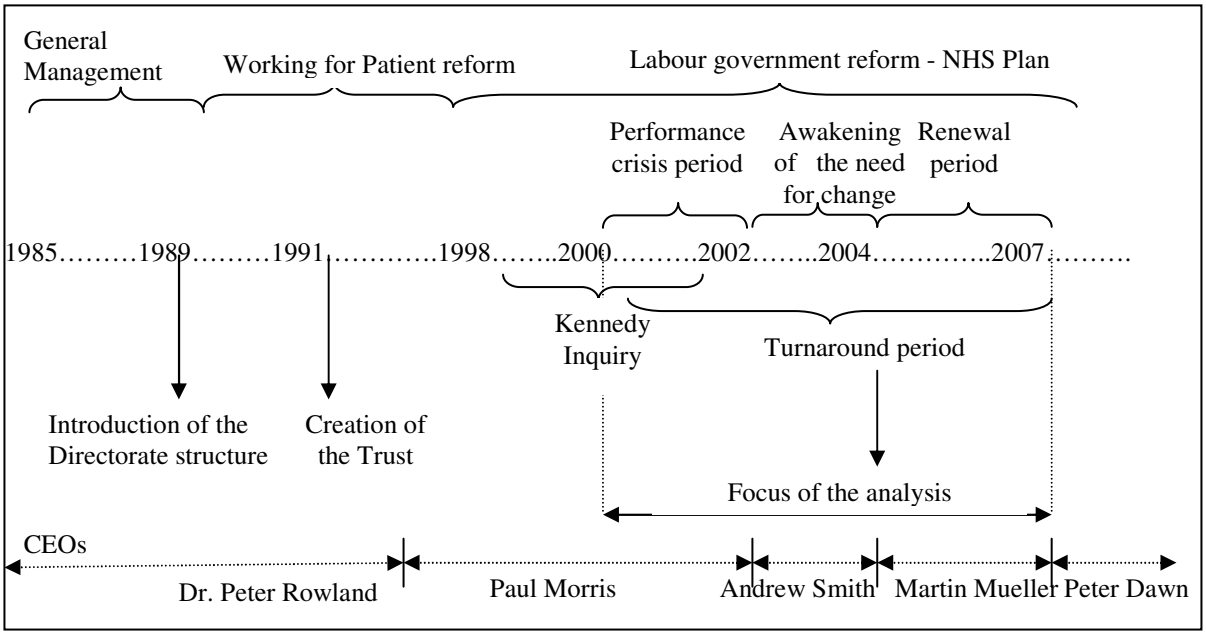
> "There is no doubt that a substantial proportion of senior managerial board and clinicians time was focused somewhere other than on the Hospital Bnd on the services; absolutely no doubts about that at all. I had regular meetings with the CEO where I guess we spent 60% of the time talking about the consequences and what was happening in the public inquiry and what was appearing in the press and how we were going to reputation manage…so we were not there spending that time talking about how's the finance going, or how's the performance going."

By 2000, in Whitehall, a new performance management agenda for the NHS was ready to be launched, as an effect of the '2000 *NHS Plan'*. This plan set up a tough performance governance system, by which all trusts in England came to have their

[22] Ibid. p.26
[23] Ibid
[24] Ibid

annual overall performance assessed and published against a set of targets and performance indicators. In the first three years of publication, HOSPITAL A figured in the bottom of the list of the performance of about 180 hospital trusts in England. In fact the HOSPITAL A had been the only trust in UK to receive three consecutives "zero stars", the lowest level of achievement. What followed was a period of intense effort from HOSPITAL A's top managers to recover its performance from the poor results received in the first three years of the performance assessment. This effort eventually resulted in a remarkable and successful turnaround. This turnaround trajectory was the focus of the analysis of this case (see figure 5.1).

Figure 5.1 – Key events in HOSPITAL A history



5.2 - The performance crisis 2000-2002

Taking the eye off the 'performance' ball

In 2000, when the central government launched the NHS Plan and set the parameters of the new rating system that would be used to measure the performance of the acute hospital trusts, the Kennedy Inquiry was in the forefront of the attention of the HOSPITAL A's executive team. Because of the far-reaching repercussions of the Kennedy Inquiry, a great part of the attention of the then CEO and the executive

directors had been turned to meeting the demands of the inquiry, handling the media and re-building the public confidence in the Hospital Bnd the employees morale[25].

The need to deliver on patient confidence issues and build up public image again had become the be-all and end-all, and the performance management priorities set by the government had to take a back seat. A senior manager in that period put it:

> "Because any business or any organisation that's gone through a public enquiry will know that it's pretty much all consuming, and the senior focus of the organisation is on that public enquiry, and it runs over quite a long period of time. And I think understandably to a large degree the senior figures of the Trust took their eye off the performance ball because they were focusing on the public enquiry, and that the first year of performance targets gave them a bit of a shock."

At the same time, several investments and new services were taken forward without the bedrock of having recurrent funding beneath them to support the new financial commitments resulting from these investments. Among clinicians and managers in the HOSPITAL A there was a feeling that the Trust could not afford any other high-profile clinical problem. This contributed to the rise of a risk-averse culture within the Trust. An immediate effect of this risk averse culture was that authorization to spend money on clinical-related aspects, such as on new consultants' contracts, agency nursing and equipment had often been granted without a thorough consideration of their impact on the trust's finances and the necessary income source to support the consequent financial commitments. As one executive director remarked, "decisions to spend money were made in corridors and not in committees with recorded decisions for business case, and a lot of financial commitments built up over time and the Trust overspent".

Organisational structure – the quasi-autonomous, 'silos' directorates

At an 'away day' meeting held in November 2000, executive directors raised concerns about a range of managerial and organizational inadequacies in the trust. Among the key problems diagnosed by the executive team were: lack of trust-wide

[25] Interview with diverse managers in HOSPITAL A

coordination of projects and initiatives; evident duplication of effort; counterproductive activities; a 'scatter gun' approach to new initiatives; under use of existing resources and skills; lack of a patient centred approach and inappropriate decision making[26].

Any attempt to address the problems would certainly be aided by an organisational structure that facilitated the coordination among all tasks and specialties along the patient pathway, and promoted the 'corporate spirit' needed to take coherent, focused decision making. Unfortunately, the then directorate-model structure of the trust was of little help for these purposes. Quite the contrary; available evidence suggests that the semi-detached, directorate structure was by itself part of the problem faced by the organization in that period. The main consequences of the structural weaknesses in the Trust can be subsumed under two aspects, namely the difficulties in communication and decision-making due to the number of directorates, and the 'silos' culture that had arisen due to the highly devolved structure.

Number of directorates. During the period under analysis (2000 to 2002) the trust was organized along the directorate structure created in 1989. There were 13 clinical directorates, each headed by a medical director, and six executive directors, reporting directly to the CEO. Although the number of directorates was not considered particularly unusual in comparison with other trusts in the UK, given the size of HOSPITAL A[27], it resulted in many people reporting directly to the CEO, thereby raising concerns about the co-ordination capacity of activities in the patient care pathway across directorates. A former medical director commented:

> "the way in which we communicated Trust wide issues about a change of direction that we wish to invest in …meant that you had to have a meeting with all the directorates there. And it was an almost impossible meeting because it could have upwards of 30 people there. Each Clinical Director having the ability to derail the meeting if he wanted to simply by raising a point that they knew would be argumentative and therefore would filibuster out any change."

Semi-detached, 'silos' structure. The choice of a highly devolved organizational structure comprised of 'semi-autonomous' directorates that enabled 'full budgetary

[26] Minute of Trust Executive Group meeting as of November 2000
[27] Smith and Ham (2000)

responsibility and clinical decision making to be combined in a single entity', was not without its side effects. A major drawback of this structural arrangement was that each directorate started to behave as an isolated unit, thereby precluding trust-wide collaboration and the development of a corporate spirit. Indeed, the words most commonly used by managers to refer to the directorates were "silos" or "islands." As a medical director in that period remarked:

> "the issue that had always been present was the system of 13 or 14 clinical directorates where each one had its own little base and monopoly, and the analogy I used to use was that it was 13 islands in the middle of a sea that was very rough and therefore communication between the islands was really very poor, and the idea that…we would respond to the other directorates in a positive way did not occur. And we ended up with a lot of personal agendas for each of the directorates and each of the people within those directorates, and the organization was not mature enough and everybody fought their own corner"

Unclear lines of accountability and responsibilities

Besides the above mentioned organisational problems, another problem that severely impacted on the trust's capacity to react to the poor results was the unclear lines of responsibility and accountability within directorates. As a former executive director present at that period commented:

> "The lines of accountability were fudged in the directorate structure…so it wasn't clear who was the person in charge of that directorate if something went wrong. An absolutely critical decision was: was it the clinical director? was it the directorate manager? There was no clear reporting and they sort of tended to act more as a pairing rather than one reporting to the other"

Evidence suggests that the ambiguity regarding the lines of accountability and the lack of clarity in relation to the responsibilities of clinical directors and managers was not a new problem, but an unresolved issue that followed the introduction of the directorate structure in 1989. Indeed, different witnesses listened to during the Kennedy Inquiry provided different views of the line of accountability within directorates and between them and the central management. One witness stated that the general

managers were accountable to the clinical director; others suggested that general managers reported directly to the director of operations; and another that the general managers and clinical directors were jointly accountable to the Chief Executive.[28]

Ineffective managerial-clinical relationship.

In a professional bureaucracy like a hospital, where professionals (e.g. clinicians) are responsible for most of the operational work and enjoy considerable power over resources and operational decision making, an ineffective managerial-clinical relationship becomes a hallmark of a non-receptive context for change[29]. In HOSPITAL A during the performance crisis period under analysis, the tensions between clinicians and managers were striking. Despite the emphasis the Department of Health was putting on the need for the trusts to deliver on the targets, there was a general perception among clinicians that the targets were a non-valid indicator of Trust's performance and something that should not be striven for. Thus, the managerial agenda, notably the performance targets, were often viewed with *indifference, suspicion* and *cynicism* by many clinicians in the HOSPITAL A. As one former clinical director remarked:

> "at that time there was a lot of cynicism from a lot of the clinical members of the Trust with regard to the validity of those markers as a measure of the efficiency and also especially with regard to the performance of high levels of clinical care…So there was a dichotomy between chasing for 'stars', which was very much a performance led as opposed to a quality issue, over the quality of care that we felt we should have".

Within the directorates, clinicians had often been excluded from the managerial decision making processes. The managerial and clinical agendas had, to some extent, lacked a common ground, and have been described as following two distinct and highly dissociated streams:

> "it [the directorate structure] had clinical directors whose engagement in management was variable. It had general managers of those directorates who

[28] Smith and Ham (2000).
[29] Pettigrew *et al* (1992)

very much looked down the general management work stream, so didn't always work with the clinical directors; either because the clinical directors weren't engaged, or because it wasn't seen as appropriate that they needed to engage the clinical directors. So there was a real disharmony between the general management stream and the clinical management stream."[30]

5.3 – Changes in the external context - Increased environmental pressure.

During the first two years of the century the NHS and the Strategic Authorities, more particularly, were going through a period of structural upheaval[31]. The 2001 '*Shifting the Balance of Power*' initiative imposed a radical change in the organization of the health authorities in England, which involved a reduction in the number of health authorities from 95 to 28. The health authority to which the HOSPITAL A was accountable in that period was dissolved. The Trust then became accountable to a newly created Strategic Heath Authority SHA, which encompassed the population that had previously been covered by the three previous Health Authorities of these geographic regions.

The changes in the Health Authorities came into effect in 2002 and were preceded by a long period of consultation. The Health Authority of Hospital A had been alerted beforehand that it would go through a significant change. The announcement of the changes was followed by a period of uncertainty within the Health Authority. This uncertainty had the effect of generating inertia among the top management team of the Health Authority, notably with regard to the pursuit of the performance agenda set by the Department of Health. As a member of former Health Authority remarked:

"No one was in charge, no one was taking responsibility. The accountability for local decisions was completely at sea, so we have the critical period of 2001/02 where key decisions were not being made. This allowed more money to seep out of the system. More... it allowed more advances if you like in terms of provider position. "We are going to build this, we are going to do this, we are going to do that." No one was checking, no one was saying "hold on, hold on".

[30] Interview with a former clinical director
[31] See also Ham (2004)

Therefore, despite the poor results received in 2001 and 2002 by major trusts in the region no significant pressure from the Health Authority was brought to bear on the trusts to implement the national performance agenda. However, this relatively 'unchallenging' context did not last too long. Soon after the creation of the Strategic Health Authorities in 2002, the implementation of the national performance agenda returned to the forefront of attention in the Department of Health. Because of the consecutive failures of major hospital trusts in the SHA region, notably HOSPITAL A and Hospital B, the expertise and ability of the SHA was called into question[32].

In autumn 2002, Alan Milburn, the Secretary of State, intervened directly to dismiss the CEO of SHA. During the Christmas period of the same year, Jackson Cameron took over as the new CEO of the SHA. Cameron's initial action was to do a stock-take of the capability of the Strategic Heath Authority, the senior team in the Strategic Heath Authority and of the leadership of the problematic trusts in the SHA region. After three months in office, he replaced most of the Executive team of the Strategic Health Authority and oversaw the introduction of new leaders into Hospital B, HOSPITAL A and another hospital trust in region.

In addition to the change in leadership across key trusts in the SHA region, Jackson Cameron spent much energy in forging a more active performance management style in the SHA. A key step in this direction was the appointment of Christina Craig, a former Director of the Department of Health for the South of the country, as Director of Performance of the SHA. Christina was reckoned to be an individual who adopted a close monitoring style of the performance of the healthcare providers in the region. Jackson Cameron introduced a new performance management regime characterized by more frequent monitoring and direct intervention in the trusts. As a former Director of the SHA Health Authority recalled:

> "Jackson moved the performance management system from a very slow reporting system, you know from one month to the next, to a system of active intervention, of active weekly, daily monitoring in terms of patient waiting, in terms of a system of reporting that also had weekly intervention, weekly phone calls, weekly determinations by the Director of Finance and by the Chief

[32] Interview with a former director of the SHA.

Executive in those areas. So suddenly a real cranking up of the energy involved in personal intervention".

5.4 - Awakening of the need for changes (2002-2003)

It was not until the beginning of 2002 that the trust started to pay more attention to the problem of the performance targets and financial overspending. The first initiative in this direction was the creation of the post of Director of Performance Management, followed by the appointment of Richard Stuart as the first director. Previously the performance management function of the trust was part of the responsibility of the former Director of Strategic Planning and Performance Management. By dividing the post of Director of Strategic Planning and Performance Management and appointing a new Director who would have his attention focussed entirely on Performance Management, the trust's response to the performance problem started to gain traction.

From the outset, Richard Stuart believed that most changes in health service delivery can only be executed if the consultants accept it and engage with it. Thus, he dedicated much of his energy as new director of performance management to forging an acceptance and commitment of the clinical community to the performance targets:

> "My personal approach was to meet the consultants, to be very direct with them… I said that whatever they thought about the quality of their service, the targets were the most important thing and if they didn't accept the targets then they shouldn't be working in this trust, and I said they should leave…. so there were letters that went everywhere… I spoke… to various [consultants] about their targets, cancer targets and they would get very upset with me, but I wasn't getting angry, I was just saying this is the priority….and they would say no it isn't, and I would say "but the British Medical Association says that you have a duty to provide the best patient care, and the best patient care does include the waiting times. So your own Royal College of Surgeons says it does include the waiting times, so it is your professional responsibility to help hit the targets". And there was resistance but I just kept saying that message".

The resistance of some clinicians did not emerge to the point of an open confrontation or any other form of organized opposition inside the Trusts. It rather took

the form of a 'passive' resistance of some clinicians, mainly in terms of lack of ownership and engagement with the managerial agenda, whether because they believed the managerial priorities were conflicting, or because they did not perceive any common ground between the managerial agenda and what they considered be their professional priorities.

At the same time, Richard Stuart started to implement a new performance information system and regular meetings with general managers to press them to exert a tighter control over the operations that had a potential bearing on the achievement of the targets:

> "I implemented meetings where I held the general managers, the directorate managers to account... with the patient names on the waiting list in front of us, and I would say 'what about Mrs. Bloggs? She needs to be admitted in 3 week's time or she's going to be a breach. Why haven't you issued her an appointment? And they had to know all the patient names on the list, and they'd not done that before."

This initial effort, however, had started when the trust approached the end of the 2001/2002 financial year and, therefore, too late to produce any significant impact on the performance of that year. In July 2002, the Department of Health published the results of the second wave of ratings referent to the financial year of 2001/2002, and the HOSPITAL A received its second "zero star," due to two significantly underachieved targets and three underachieved targets.[33]

Soon after the publication of the 2002 performance ratings the CEO, Paul Morris, left and the financial director, Andrew Smith, became the Acting Chief Executive. This was seen as a temporary arrangement, since the intention of the Strategic Health Authority, with the consent of the Department of Health, was to initiate the process of "franchising", that is to contract out a private sector organisation to operate the management of the trust. In December, just before Christmas, the arrangements for franchising the trust were announced. The strategic health authority

[33] Significantly underachieved target: "twelve hours trolley waits" and "Financial management". Underachieved: "Eighteen months inpatient waits";"Cancelled operations" and "two week cancer waits".

pursued the franchising of the trust quite heavily over about a year, when several candidates put themselves forward[34].

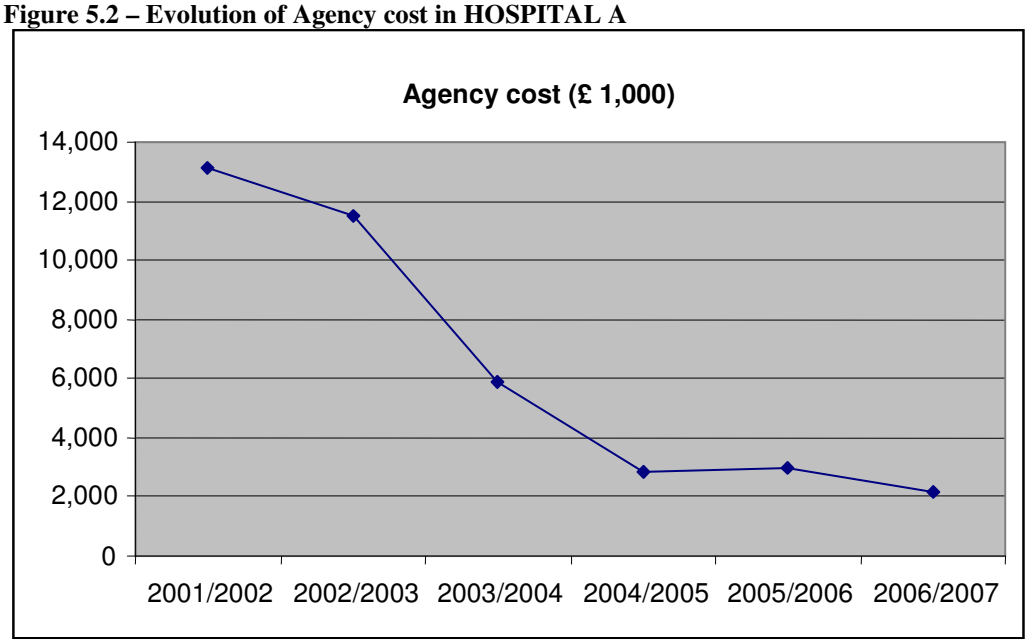
During the same period the executive team became very focussed and determined to bring about financial recovery. Several recovery plans were put forward and negotiated with the SHA. The top-managers' approach for financial recovery was to address both the 'expenditure' and 'income' sides of the Trust's finance. Regarding the expenditure, the executive directors believed that there were massive savings to be had on procurements and started to implement a wide range of cost-cutting measures, such as imposed savings to directorates and tougher policies on vacancy recruitment. One executive director described the behaviour of the board as follows:

> "…we became very tight as the directors of the board, very short-term, very action orientated, very problem solving, very directive to the rest of the organisation […] We paid much more attention in 2002/3 to delivering savings. And we caused some upset in the organisation because we started cancelling money for staff to have tea and cakes, you know, unnecessary expenditure we just stopped, and we put savings plans in."

The Trust's spending in agency costs, especially nursing, was seen by the directors as the villain of the piece, which in the 2001/2002 financial year totalled £ 13 million. In that period, the trust was facing great difficulty in recruiting nurses and frequently had to turn to staff agencies. Thus, a considerable effort went into reducing the Trust's dependency on agencies to supply nurses. Major initiatives in this direction included international recruitment, the adoption of strict polices regarding the use of agency staff and ending the use of the most expensive agencies[35]. As a result the trust achieved significant saving on agency costs, thereby contributing to break even in the 2003/2004 financial year (see figure 5.2).

[34] Minutes of Trust Executive Group meetings and interview with executive directors.
[35] Interview with two executive directors.

Figure 5.2 – Evolution of Agency cost in HOSPITAL A



On the 'income' front, the top-managers' team started to impose a harder negotiation with commissioners in relation to the remuneration of the services they were providing and stopped creating new services that would not have the support of recurrent funding: "What I would say is that we started to drive a much harder bargain with the commissioners saying, you know, 'we aren't any longer prepared to give you open access to walk in X-Ray services. If you want that you pay for it.' and I think to some extent we were successful to that end as well as in control of expenditure."[36]

At the same time in the SHA, the difficulties in finding a suitable candidate to run the management of the trust in a franchising-based contract, coupled with an optimistic view about the efforts the team of directors were making to secure financial balance and performance improvement, led the SHA to suspend the franchising process in April 2003. Indeed, in July 2003, soon after the Trust had received its third 'zero star', Jackson Cameron expressed his confidence in the efforts the Trust was making to improve its performance as follows:

> "The Trust met all the targets set within the plan but their progress has not been sufficient to move the Trust up. There are fixed points in the star ratings and given the extent of the problems at HOSPITAL A it would have been

[36] Interview with a former member of the Trust Board.

impossible for them to achieve financial balance in so short a time. However, the trust deserves due credit for the improvement that has taken place there."[37]

The combined efforts of the executive directors team to impose finance discipline, to make divisional managers pay more attention to the targets and to increase the engagement of clinicians with the targets, eventually achieved an impact on the Trust's overall performance and led it to receive "two stars" in the 2003/2004 performance rating.

5.5 - Renewing the organisation: creating strategic and operational management capability - 2004-2007

Building up the executive team

In April 2004, following the strategic health authority decision to cancel the franchising process of the trust, Martin Mueller, a senior manager with a strong business education and wide experience in managing large and complex organisations within the NHS, was appointed as the new CEO of HOSPITAL A. Martin Mueller's initial impression was that, although the Trust had succeeded in stopping overspending and improved the performance against some targets, it had not in place the organisational processes and structure that could lead to a sustainable turnaround:

> "my feeling in 2003/4 was that although the Trust stemmed haemorrhaging of the financial position, they made very limited progress on the performance…What we got at the end of that was a estimation of financial end point in the year which was satisfactory, a far better out turn than before, but the price that was paid for it was considerable in terms of things that hadn't been done or addressed…. So it was a genuine first stage of a turn around in the sense that everything was just blocked. You know, the biscuits had stopped and all that sort of stuff rather than a... rather than a sort of planned turn around".

Martin Mueller entered office intending to improve the operational management capability of the top managers team so that he could devote himself to the strategic issues of the trust. What drove this intention was Martin Mueller's sense of the role of

[37] HOSPITAL A News Release, 16 July 2003

CEO: “I believed that there was so much to do externally that it was vital that I could have the confidence there’d be somebody there who could run the day-to-day short term life of the trust without me being dragged back into that all the time when I wanted to play on the external stage,[ ] in order to ensure that the Trust had a more influence over the external agenda and environment”

During his first year in office he dedicated himself to building up the executive directors team’s capability to manage the operations of the Trust. His initial diagnosis of the situation pointed to two major deficits in this capability, as he described: “I identified two major gaps in the organisation that needed to be filled, one was a complete absence of a really serious operational management, and secondly the need for a permanent Medical Director who could actually deal with…partly with building a relationship with the clinicians, but partly actually give me confidence that the clinical issues were being properly tackled..”

The first move in the direction of enhancing the operational management capability of the trust was the creation of the post of Chief Operating Officer – COO, followed by the appointment of Peter Dawn, a medical graduate with wide experience and high-level education in management, as the first COO. The idea behind the creation of the post of COO, as opposed to the more traditional Director of Operations post, was to delegate so far as possible the day-to-day operational agenda of the Trust to someone that had more authority to change things in the organisation. As Martin Mueller remarked, “I needed somebody I could work with as a closer colleague than simply a Director of Operations who didn’t have a sense of the strategic direction of the organisation.”

As for the Medical Director position, Martin Mueller’s intention was to appoint a medical director who was committed to full-time management, especially in building up the managerial-clinical relationship. Traditionally the work time of all previous medical directors had been divided into executive management and clinical activities. After an internal and external selection process, Jonathan Sheffield, a former medical director of a managed clinical network between 8 trusts and 3 SHAs in the region and therefore with a good external view of the HOSPITAL A, took over as medical director committed to full-time management of the trust and to bring about clinicians engagement into the managerial agenda.

> "I felt very strongly that an organization as large as this with 800 doctors actually required the full-time commitment of the Medical Director, and I see… my personal role I felt was very much to engage the clinicians in management to get them to understand why management was so important, so Peter Dawn and myself and the Chief Executive did an awful lot of meetings with clinical groups and I set up consultant away days where we met with consultants and we talked about how they could help get the Trust out of its financial deficit, improve performance and how we'd do it by working with them rather than at loggerheads with each other."[38]

With the creation of the COO post, the position of Director of Performance Improvement ceased to exist and Richard Stuart became Director of Strategic Planning, devoting most of his time to looking to the future rather than to the day-to-day operational issues. At the same time as creating these new posts, Martin Mueller made it clear from the outset the roles of the directors in terms of their specific functions and the time each of them should be devoting to the day-to-day running of the Hospital Bnd to the more long-term strategic issues. As one executive director commented:

> "one of the things that the Chief Executive did at the start was make it absolutely clear what the roles of the executives were, so he made absolutely clear that the Chief Operating Officer was about the day-to-day running of the Hospital Bnd understanding what makes the hospital run and tick, and that the Medical Director and the Nursing Director were the key supports to that, and he actually said that 70% of the Medical Director's time and 70% of the Nursing Director's time should be committed to day-to-day organizational management, and that… you know, and the other 30% was for our strategic view. The Chief Operating Officer was very much 95% day-to-day operational matters, whereas the Planning Director was 95% looking to the future"

Changing organisational structure – collapsing the 'silos' directorates

After building up the executive team, Martin Mueller turned his attention to the structure of the Trust. It became apparent to Martin Mueller that the directorates

[38] Interview with Jonathan Sheffield

structure of the Trust was of no help in his effort to strengthen the operational management capability of the board and to secure clinicians engagement into the managerial priorities. As he put it:

> "from a manager's point of view I found a strange management structure where just about everybody who was anybody seemed to report to the Chief Executive, so you had about 13 or 14 directorates of various sizes that reported up to.. straight to the Chief Executive… [it] clearly had problems about span of control, it clearly had problems about where the responsibilities lay in the organisation, and it clearly did not promote clinical involvement at all"

This conviction about the inadequacy of the directorates structure of the Trust was reinforced by a report of consultancy work Martin Mueller commissioned just before taking office as the Trust's CEO. The report, known as 'Secta Review', suggested that there was little engagement in the management structure and suggested that the structure should be reconsidered.

Following initial meetings with the executive directors, Martin Mueller decided to collapse the directorate structure and go for a smaller, more manageable structure. As a executive director remarked: "we met with the other executive directors and we discussed about how we can make an organisation where there was much better engagement between the managers and the clinicians, and really we all agreed that we felt that the clinical directorate structure of 13 individual clinical directorates caused too much tension between the organisation, too much compartmentalization of management pathways, and that what we would want to go for was a divisional model where you had far fewer management groups".

However, Martin Mueller wanted to encourage participation and debate within the organisation in order to arrive at internal consensus and collective buy-in about the new structure. By the end of October 2004, Martin Mueller was ready to launch a long and intensive consultation process with the clinical and managerial community within the Trust. With the leadership of the Martin Mueller, Peter Dawn, Jonathan Sheffield and Melane Liddell, the Director of Workforce and Organisational Development, the consultation exercise lasted about nine months and involved a great number of clinicians and managers in the trust.

The consultation period resulted in the suggestion of collapsing the directorates structure and the creation of five clinical divisions. The intention was to engender collaboration and coordination of the resources among clinical specialties by organising the trust's activities within divisional units that reflected the patient pathway, as opposed to traditional individual medical specialties. The change in the organisation came into effect in July 2005, smoothly and without resistance. An influential former clinical director describes his view of the consultation process as follows:

> "there were plenty of opportunities for people to voice their opinions and, you know, to have a proper debate. The end result was a consequence of listening to what people had said and making some adjustments to the original proposals...and it was explicit why those adjustments had been made. And, you know, depending on how cynical you are you either believe that or you didn't, and I choose to believe in that…it all seemed to me to be fairly honest, you know, in the way it was approached."

Figure5.3 – HOSPITAL A's structure in 2002

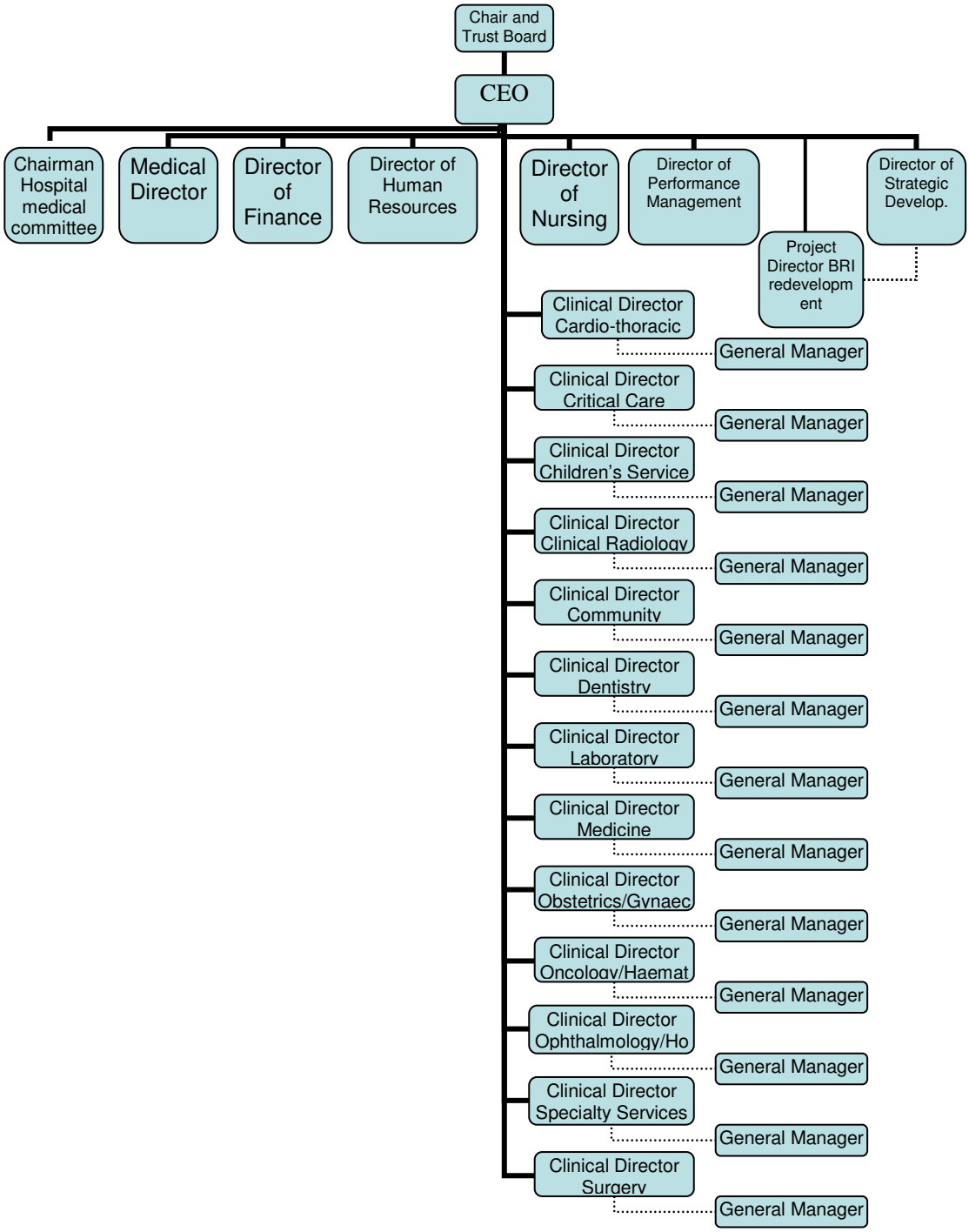
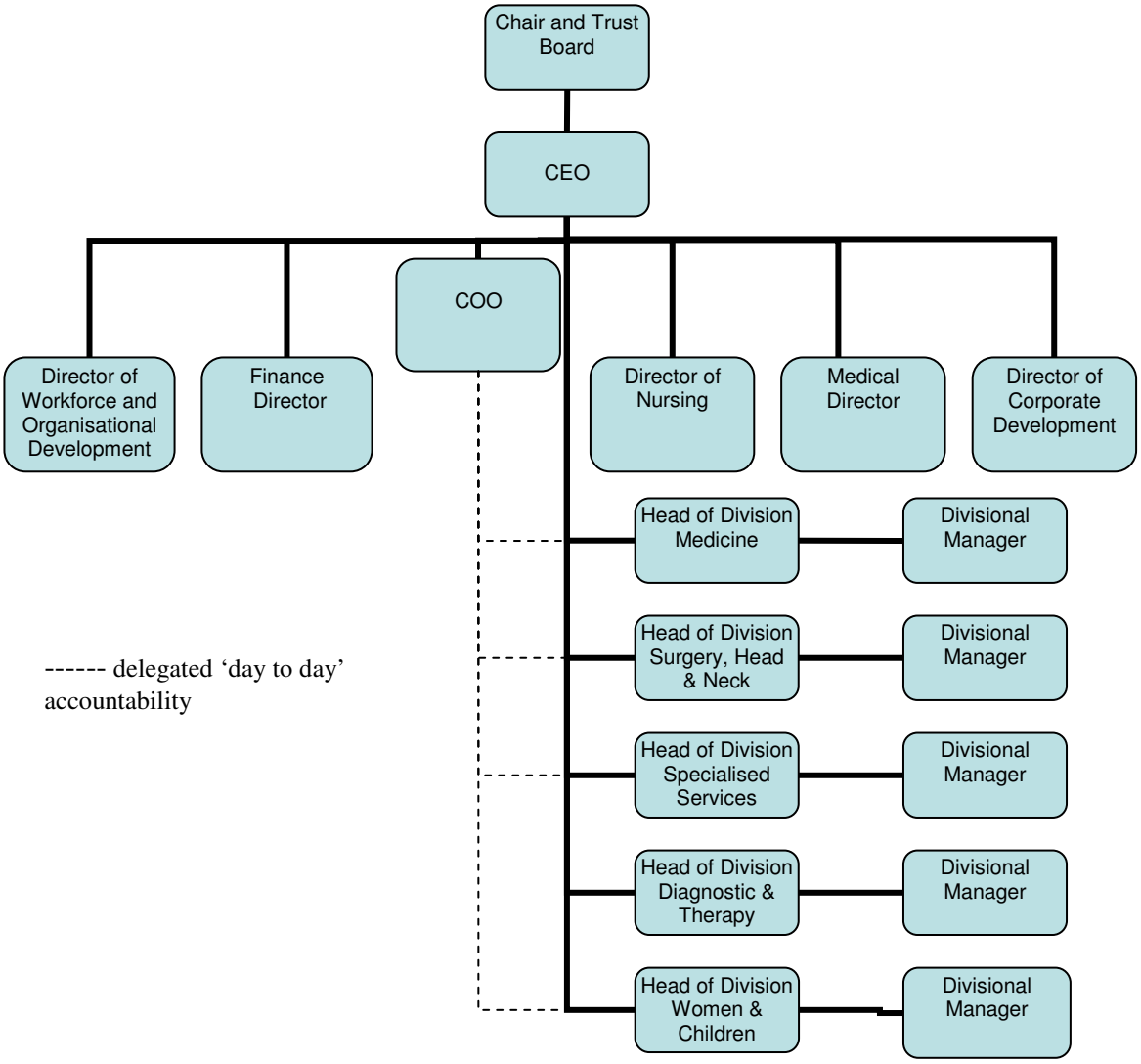


Figure 5.4 HOSPITAL A's structure after July 2005[39]



After the creation of the divisional structure, with five clinical divisions, a new division, Trust Services Division, was added: "we felt that actually the same discipline that we were applying to the clinical divisions needed to apply to corporate services as well, so we badged them as the sixth division in due course[40]".

To foster the involvement of clinicians into the managerial decisions of the divisions, Martin Mueller set up a 'divisional board' that mirrored the Trust Executive Board. The divisional board was composed of the head of division, the divisional manager, the 'lead doctors', who represented the medical specialties within the divisions, the lead for nursing, the finance lead and HR lead. The benefits of this

[39] Figure 5.4 and 5.3 were created from archive material.
[40] Interview with Ron Kerr.

collegial arrangement were thought to be generated by providing room for an effective managerial-clinical relationship in the decisions of the division, and breaking down potential resistance of medical specialties that felt unrepresented after the collapse of the directorates. As an executive director remarked: "bringing a range of people in to support the decision making in that area was an enormous behavioural change. So the fact that health professions have now got a voice on the Divisional Board really brings those professionals into being part of it"

Overall, the benefits of the structural change to the management of the trust were believed to be threefold. Firstly, it afforded a momentum for implementing behavioural changes in the organisation by choosing the best levers to lead change and setting the culture and expectations in the divisions. Secondly, it made the trust more manageable and corporate, by reducing the span of control and reducing "silos". Finally, it enabled a better coordination of activities by facilitating the integration of activities and more efficient allocation of resources that once were under different and to some extent isolated directorates and which are now under the same division.

Key people leading change

It was clear to Martin Mueller from the outset that the behavioural changes needed to bring about performance improvement in the trust would necessarily require the clinicians engagement with the managerial agenda. Securing clinical engagement was thus viewed as a *sine qua non* condition if the trust was to improve its performance and sustain it in the long run. The first move in this direction was the decision that the newly created divisions should, necessarily, be headed by clinicians.

Soon after the creation of the divisional structure, the trust initiated the selection process for heads of divisions. For Martin Mueller, to be a clinician was a necessary condition, but not a sufficient one. Above all, a successful candidate should demonstrate management capacity and be willing to dedicate most of their time to the managerial activities. As Martin Mueller put it, "we had to have those divisions headed up by clinicians. We decided even more that it couldn't be a sort of 'buggins's turn' type position, it had to be people who were committed to leadership and management and who were prepared to take on responsibilities."

Martin Mueller was concerned that no, or just a few, clinicians would put themselves forward, given the fact that the requirements of the positions went beyond those of a clinical director's post they would normally find elsewhere. However, to Martin Mueller's great relief, in the run-up to selection 13 people, mainly consultants, expressed interest and put their application forward for the five positions. All of them were then submitted to normal managerial appointment process to assess their managerial and leadership potential. As Martin Mueller remarked, "We put them through a proper recruitment process where they actually had to set out what they were going to do; how they would manage the organisation; how they would handle colleagues who were difficult; what their sense of responsibility was for delegating budgets and all that sort of [managerial activity]"

Once the divisions were formed, the respective head of divisions selected and the divisional board established, the next stage was to make sure that the key people inside the divisions understood their new roles and had the managerial ability to run their divisions. For this purpose, Melane Liddell launched a training programme, with Keele University, to help the divisional board members to consolidate and understand their roles, as well as to provide the managerial knowledge and ability they needed to manage their divisions. A divisional manager who participated in the training programme recalled:

> "when the divisions were established the Trust ran a divisional board development programme… so that was to help establish the boards, help them to understand what their task was, help them to get to know each other, help them to start to think about their learning strategies and how we were going to do that. That was a great investment and again I think it showed people in the divisions, sitting on the divisional boards, that the Trust was serious about making this change and about giving the divisional boards the opportunities to develop".

On the Board front, Peter Dawn, Jonathan Sheffield and Martin Mueller exercised firm leadership in engaging clinicians, especially consultants, into the managerial agenda. Apart from the active role they all played in the selection of the key leaders to work in the divisions and its consequent effect in the clinical-managerial interface, they acted directly with clinicians to effect a commitment of the clinical

community and offset the influence of opposing people in the organisation. The key formal initiative they undertook was the consultants 'away days' set up by Jonathan Sheffield when they put together 30 to 40 consultants to discuss issues of the trust's strategy and performance. The consultant away days turned out to be a great opportunity for Jonathan Sheffield and Peter Dawn to not only get clinicians to understand the challenges, but also gain allies in their effort to build up clinicians engagement with managerial priorities. As Peter Dawn recalled:

> "that [the away days initiative] was excellent because what we had was some negative leaders spreading rumours that nothing will ever happen, it's all awful, it's not worth trying, it's not worth engaging, and when myself, Martin Mueller and Jonathan Sheffield met directly with all of the consultants we could tell them what was really happening, so that negative people…influence of the negative people dropped and we could get to the average if you like consultants. And so yes it is worth the effort. This is the reality, this is how we get out of it, and so we got much better engagement after all".

Clarifying accountability and controlling performance.

Along with the changes in the structure and the selection of key people to manage the divisions, the executive team made it very clear from the outset their lines of responsibility and accountability. The first step in this direction was to clarify the lines of responsibility and accountability between Heads of Divisions and Divisional Managers, preventing the trust from suffering from the ambiguity that pervaded the old directorates arrangements regarding who was accountable to whom and for what. The Heads of Divisions were held accountable for the performance of their divisions on all aspects, with the Divisional Managers reporting directly to them. An executive director commented: "it is absolutely transparent now that at the end of the day if the Women's and Children's division overspends, [the] Head of the Division is the person who has the overall responsibility".

Martin Mueller and Peter Dawn sent the message across the whole Trust, clarifying the responsibilities of Head of Divisions and Divisional Managers and holding them accountable for their performance. In the words of a Divisional Manager: "Martin Mueller and Peter Dawn were very clear about what they expected from Heads

of Division and Managers, and they very much expected us to deliver and not interfere in that. And so I know that if I don't deliver financially, or on targets, or on governance, that I'm responsible and I'm held to account.".

Such a message about the lines of responsibilities started to be assimilated by managers across the trust and take effect. An executive director illustrated the effect of the clarification of the responsibilities across the trust as follows: "with the cash releasing efficiency requirement, we have to do that year on year, release a firm percentage. Up to the change of divisional structure predominately it was the [executive] directors who came up with the ideas about how we're going to do that and manage that. Even manage things like controlling whether people can fill posts or not. Now it is absolutely clear it is the division's responsibility to do that."

The clarification of the responsibilities and accountabilities went hand in hand with the intensification of the use of performance monitoring and feedback mechanisms. Up to the changes in the structure, the performance of the trust was monitored by Richard Stuart's team by means of a Balanced Scorecard he introduced to serve as tool to give managers an overview of how the directorates were performing against the key targets. With the changes in the executive team, Peter Dawn's team took over the responsibilities of performance monitoring and improvement. Although the existing system allowed the trust board to identify how well the trust had performed against the key performance targets and indicators, Peter Dawn and his team felt that the performance information was still not well understood and completely used throughout the organisation. Peter Dawn believed that if the organisation was failing on a target, it needed to become an expert on that target, in the sense of having a clear understanding of the definition and the factors that impact that target. Peter Dawn's team started to produce this information, feed it back to key people and teach people about the understanding of the targets:

> " we have daily data coming to about 40 people on the 4 hour wait target. And it shows the previous day's performance and the cumulative for the week. So, whether it's getting better by the end of the week etc etc. And then we introduced probably tighter reporting to the board, so on specific indicators like that we introduced more frequent monitoring, brought the data into meetings that were considering what we needed to do, and we made sure that the people

who could do something about it received the data, because they didn't always know what was going on. And it helped us decide whether we were on track or not on track, or whether we needed to do more".

The performance information system evolved into what is called "performance tracker", which emulates the Healthcare Commission's targets and provides a coloured report (yellow, amber and green) on the trust unit's performance against all targets. With the performance tracker in hand, Peter Dawn and his team intensified the performance feedback to key people in the organisation. Peter Dawn wanted to make sure that information on the performance had really been received and used by key people in the organisation, as well as sending an implicit message that the performance of the divisions is effectively monitored and a matter of great attention from the top of the organisation. An important initiative in this direction was the decision to pin up on the doors of key managers' offices, on a monthly basis, the coloured report of the performance of their respective units against the key targets, accompanied by Peter Dawn's comment about what they need to concentrate on over the next month. A divisional manager described the operation and impact of this performance feedback system as follows:

> "[one of the key things that helped us to achieve the targets was] the provision of information in a form that made it easy for the Execs to track what happens, and when things are going off beam, and easy for us as Divisional Managers to interrogate and understand which bits of our divisions are not performing…There's a monthly performance tracker which is stuck on my door… It shows performance against each of the targets… He'll (Peter Dawn) come around with a piece of paper and stick on the door of all key managers… So it's very… you know, you're being watched and you know your performance is being watched, and you know your performance goes on a beam, so it's about keeping focus… and it's very tangible."

Fostering a 'bias towards action' culture

On the cultural front, it became apparent to Martin Mueller and Peter Dawn that much still had to be done to increase the managers' willingness to act, or in other word, to counter tendencies for managerial inertia and inaction in face of some difficulties.

This 'bias towards action' was viewed as necessary to respond to adverse situations or potential challenges and opportunities that might have a bearing on the organisation performance. Yet what Martin Mueller first found when he came into office was a strong risk-averse culture, or in the terms of him '*capacity for inaction'*, in which managers flinch from difficult decisions or taking risks:

> "[what] was very strong when I first came into the place and is still not completely eradicated is a bias to inaction. 'If in doubt don't'... quite strongly, this is quite strongly built into the culture and getting people to say its alright to take risks as long as you've mitigated them, as long as you've identified them and thought about how you handle them, you are as liable... likely as anybody else to have the right answer. You're on the scene, get on and do it. You know. Or you'd have a meeting where there'd be 20 people in the room, everybody's saying "wow, yeah we're gonna do this" and then one person would say "oh I'm not sure". It's like pricking a balloon, they'd all go "oh, alright then". So there was this huge negative power that existed which we had to get over*"*

This impression of a 'bias towards inaction' was also shared by Peter Dawn since he took office as COO in September 2004. This impression was confirmed soon after the first meetings he participated in as COO with managers in the trust: "there were a million excuses for poor performance which were used in every meeting. A selection of about ten excuses I heard in nearly every meeting, so "we don't have enough money, the Primary Care Trust won't let us, the Strategic Health Authority won't let us, Hospital X won't let us, the doctors won't let us, the managers won't let us" so there was all these excuses for not doing anything, or it was always somebody else's fault…They also believed that they were a special case that needed more funding and so nothing was possible unless that funding came.*"*

Peter Dawn described himself as having a strong preference for action, developed mainly from his business education at INSEAD in France, where he attended a MBA programme, and his previous experience in private sector management consulting gained during his work at Boston Consulting Group in the United State of America. He strongly believed that the organisation has control over its destiny and that if the organisation is not performing towards a target something needed to change. Therefore, willingness for taking action was thought of as essential to bring about the

changes needed to improve and sustain good performance. This conviction led him to dedicate much of his energy as COO to fostering a 'bias towards action' culture among the managers in the organisation.

> "we had…lots of excuses for why things were poor. So if there was an overspend on the budget and we'd had a financial review we'd spend 80% of the time talking about why its overspent, and only 20% of the time on what we're going to do. So we changed that and said "we need to understand the root causes for the overspend, but let's understand those quickly and then let's spend the bulk of time talking about what we're going to do". So I think we instituted something called a variance explained is not a variance managed, so you know, if you explain an overspend, it's still an overspend. So you have to manage it."

Peter Dawn kept on fostering this bias towards action culture among key managers in the organisation. He set up an informal conduct policy in which all meetings had to end up with a action plan together with the names of people responsible for taking the actions and, in the next meetings, he called to account people who failed to deliver their part of the action plan. A Divisional Manager recalled Peter Dawn's efforts as having a significant impact on the way managers behaved in the face of a problem: "…the culture is quite hot on personal accountability. So Peter and Martin are very hot on "we don't want your excuses, we want your solutions. We want your answers, we want…" so you can't ever go and say "I didn't know, I wasn't sure, I didn't understand"".

Enhancing operational and strategic decision-making capacity

From the outset, the devolution of operational decision making to the divisions was uppermost in Martin Mueller's mind. He wanted the division to be capable of dealing with their own operational issues and have a long-term clinical strategy consistent with the demands of key external stakeholders, so that he could devote himself to the more strategic issues of the trust. Yet he believed that the divisions would not be able to sustain good performance unless they had a good corporate governance structure and a sound strategic management process: "one of the things I would say is critical to a turnaround is governance goes out of the window. So in other words to complete the turnaround you've got to get the governance absolutely rock solid." In

terms of structure, the establishment of the Divisional Boards, which put together key clinical specialties and managerial function of a division within the same room to discuss operational and strategic issue, was a key step in this direction.

However, for the divisions to have a coherent sense of direction, which was consistent with the demands of external stakeholders, some work still had to be done. After setting up the divisional boards, Richard Stuart, now as Director of Corporate Development, ran a series of strategic events for each division, involving a great number of people, to discuss strategic issues such as the external environment, stakeholders' demands, the division's strength and weakness, and from that to formulate its clinical strategy. This event provided divisions with coherent strategies and a clear sense of direction, which were considered instrumental for Martin Mueller's efforts to devolve responsibility downwards. As a Divisional Manager remarked:

> "the other thing that we did very soon when the divisions were set up was a focused exercise on developing clinical services strategies for the division… so now as a division we've got a direction, we know what our destination is in 5 years time. You know, we clearly mapped out where we want to go… So rather than lurching from year to year surviving, we're now… we've now got a future and that is fundamental in terms of performance management"

In parallel to the creation of the Divisional Boards, Martin Mueller revamped the trust-wide decision-making process. The purpose was to provide formal horizontal linkages for achieving better coordination across units and a more corporate spirit. Before the changes in the structure, the formal mechanisms for achieving some shared decisions and some cooperation across units was operated through the Trust Executive Group – TEG. However, at that time both the number of people attending the TEG and the scope of issues discussed was considered too wide to enable more productive and effective corporate decisions. This problem was addressed in two ways. Firstly, the collapse of the directorates and creation of a smaller divisional structure had obviously reduced the number of people participating in the TEG. Secondly, regarding the lack of focus of the meetings, Martin Mueller and Peter Dawn created the Trust Operational Group – TOG to deal with operational matters and left the more strategic issues to the TEG to discuss. In the words of Peter Dawn: "we clarified which group made what decision, so you know, it was not clear before then what the Trust Executive Group was

for. [So] we introduced a Trust Operational Group so that the more minor operational matters could be considered by the Trust Operational Group, and more Strategic things by the Trust Executive Group."

In terms of processes, Martin Mueller and his executive team started to insist on the adoption of more robust managerial process and procedures to underpin key decisions in the organisation: "Planning, plans, processes, procedures, documentation, risk analysis and everything else has got to be absolutely robust. No successful organisation will not have those." A major development in this was the requirement for a more robust business case to make a decision, specially those that involve financial cost to the organisation. In the words of Peter Dawn, "we now insist on business cases for all key decisions whereas before it might be just two paragraphs on how this has to be funded.. Now we say we need a proper business case with options, risks, costs, capital costs, revenue costs then we make a decision. So we never take a decision without a proper description of why… I think that's helped us a lot actually in terms of being clear about what we're doing and why. How it fits to strategy, how it fits to our risks and what the trade offs are, and the key processes."

At the trust board level, Martin Mueller wanted to strength the linkage with the local community, so that the trust would be better prepared to identify and respond to its demands. In his view, the trust had become incredibly insular, thereby losing connection with its local community's aspirations and demands. Furthermore, he recalled having an important gap in terms of quantitative experience among the non-executive directors, which, in some sense, made the board deprived of useful information from the business community: "I inherited non-executives with limited quantitative experience. You know, there was no accountant, no lawyer, no economist… no [people with experience of this nature] on the Board".

To overcome this gap in experience among the non-executive directors and to increase the board's ability to identify and consider the local community's aspiration into the trust's strategy process, Martin Mueller set up the Community Advisory Group and the Business Advisory Group. The former was basically composed of representatives of voluntary sector, local authority and community type people, whereas the latter was drawn from the business community. Martin Mueller describes the purpose of those groups as follows:

" they were there to advise the board on whether the policy and strategy we're developing are sellable in the local community. Do they meet what people want? How could we adjust them so that they do that? And on the business side they were basically... basically told the guys that came in we said "we think we understand the health service, we understand health care. We understand all the issues around it. To a significant degree more than you, well, inevitably. We've also got a stakeholder group that's thinking about what patients and public opinion are. What we want from you is... are the things we're doing sensible for a £350 million turnover business employing 7,000 staff. We want your generic business advice on that side of things. And those groups were formally put into the cycle of meetings so that they could hopefully improve the strategy."

Managing Externally

Having resolved the transformation of the trust and created the conditions for the Trust to manage its operational performance without the need of his continuous, close involvement Martin Mueller could devote more time to managing the external relationship with key stakeholders of the Trust. One key move in this direction was to have one-to-one meetings with the CEO of key stakeholder organisations in the region, including the other hospital trusts, local organizations and commissioners. With the company of the Medical Director, Jonathan Sheffield, he visited all hospital trusts in the region that sent patients to HOSPITAL A. The intention was to meet their counterparts in those trusts and to discuss potential common agendas that could benefit both organisations. He agreed to establish joint executive-team-to-executive-team meetings with Hospital X, which is the HOSPITAL A's closest competitor. These joint meetings helped to identify some areas of joint interest between them and a positive agenda for future collaboration. With the commissioners, Martin Mueller also set up more frequent meetings with the CEO of Primary Care Trusts, where he sought to sell what the HOSPITAL A was doing. Such a network was viewed as a key step forward to consolidate a positive reputation of the HOSPITAL A in the health economy[41].

As for the other local organisations, Martin Mueller started to spend time networking around the city with influential people. This networking was accelerated

[41] Interview with the COO.

with the appointment of the new Chairman of the Board, John Savage, in December 2006. Having come from the business community, where he held the position of CEO in diverse business-related organisations, John Savage was able to connect Martin Mueller with the business community more successfully. This networking helped the spread of a positive image of the Trust in the business community, which was thought of as essential to increase the organisation's prospect of receiving money in future negotiations.

Martin Mueller's strong network with key external stakeholders had also a positive effect inside the Trust, in terms of improving the morale and confidence of its employees. His connection with the key people from the more direct governmental stakeholders, gave the employees the sense that both Department of Health and Strategic Health Authority were listening to them and giving them more credibility. In the words of Peter Dawn:

> "Another thing people talk about when they talk about Martin [is that] he allowed us to feel confident again. It was something about building organizational confidence. And I think the fact that he was talking to people externally and nationally, and he had a massive national network, made people feel like if we were somehow protected, but also he was selling what we were doing externally, and it just gave people a sense of security and less feeling like they were under scrutiny and under pressure."

As a result of all the efforts and changes implemented in the organisation, HOSPITAL A went through a successful turnaround trajectory, culminating in the achievement of the highest score in the annual performance assessment published by the Healthcare Commission for the 2006/2007 financial year, and in the prospect of a financial surplus of about £ 12 million for 2007/2008 (see figures below).

Figure 5.5 Evolution of HOSPITAL A's performance ratings

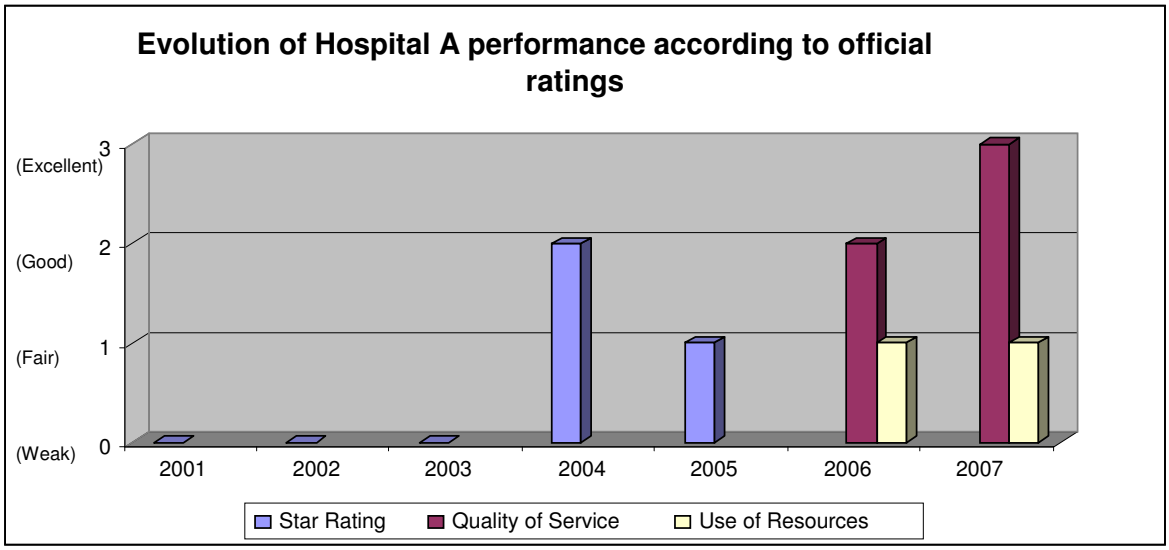
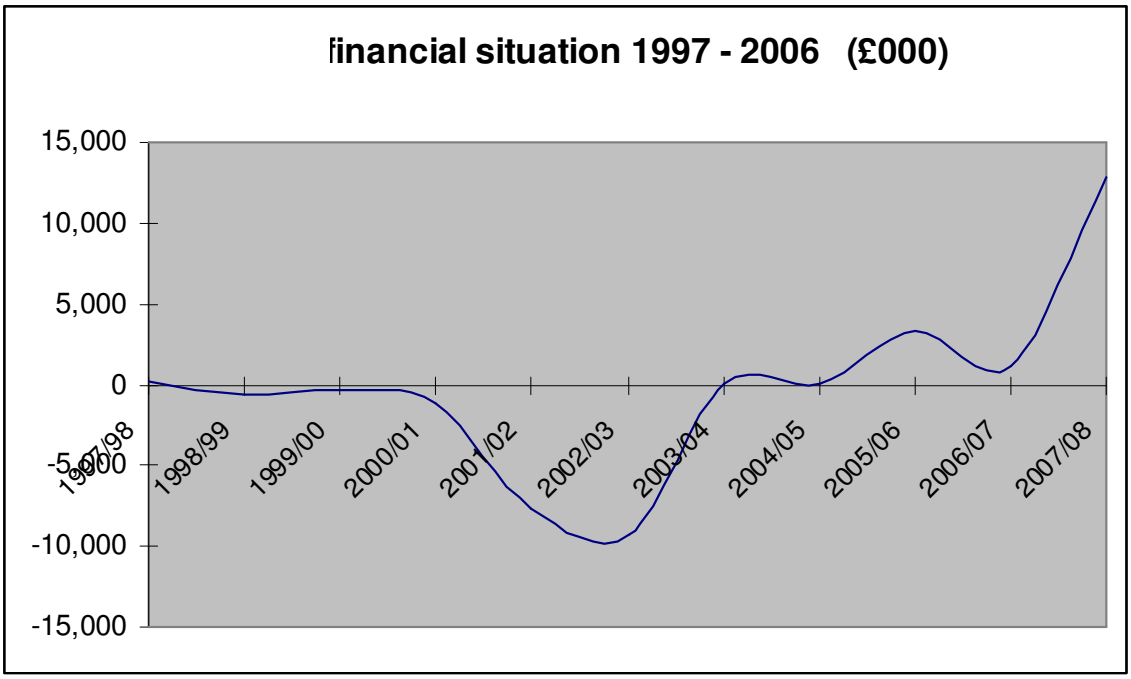


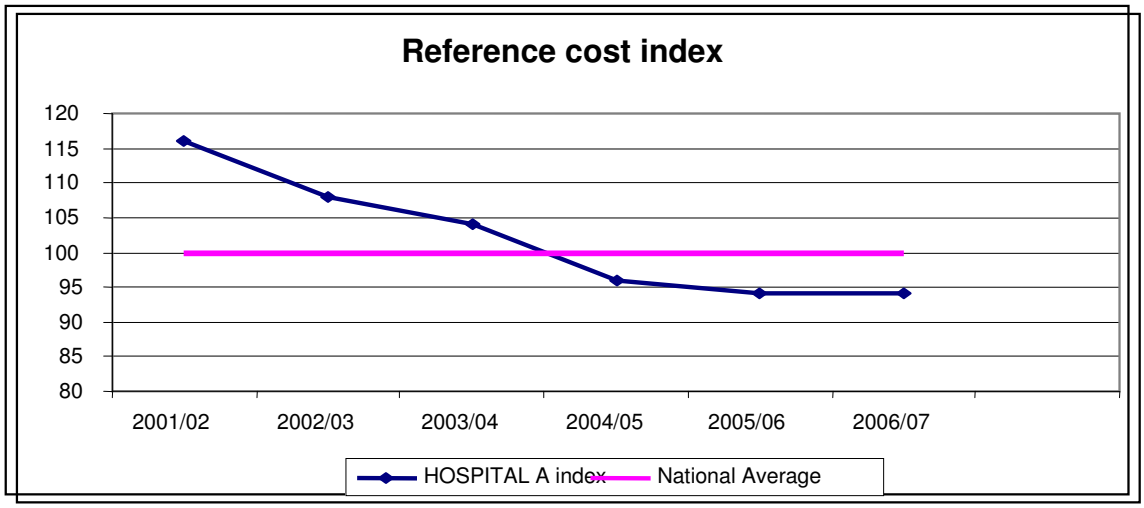
Figure 5.6 Evolution of the financial situation of the trust[42].



The improvement in efficiency of the trust is also demonstrated with reference to the evolution of the National Reference Cost index – RCI -over the period concerned. The RCI is a score, calculated and published by the Department of Health, that demonstrates the relative efficiency cost of each trust compared with national average. The graph below shows how the cost efficiency index of HOSPITAL A improved in relation to the national average index form 2001 to 2007 (reference cost = 100).

[42] The value referent to 2007/08 is forecasted with basis on the finance situation in Dec/2007. Source: minute of the Trust Board meeting as of Dec/2007.

Figure 5.7. Evolution of efficiency cost of HOSPITAL A in relation to national average[43]



5.6. Recent developments – introducing the 'Lean Thinking'.

After the transformation of the Trust had taken place, Peter Dawn, as directly responsible for the operational performance of the Trust, channelled his attention into finding new ways to make the organisation operationally more efficient. His management education and continuous contact with management literature helped him to keep updated with recent developments in the management field, especially with regards to novel management practices in healthcare organisation. He then came across the application of Toyota's "Lean Thinking" in service organisations and the early trials of this practice in Bolton Hospitals NHS Trust.

Peter Dawn became interested in learning more about the potential of "Lean Thinking" and its feasibility in healthcare organisations. He invited external speakers, including the CEO of Bolton Trust, to present some cases of adoption of this idea and freshen up the managers' thinking about this topic. This interest was increased as Peter Dawn learned more about 'Lean Thinking' and its application in healthcare organisations:

> "I have read about it, but it got me more intrigued than what I thought it was possible to do something specific in healthcare. I started reading about the NHS

[43] This chart can be interpreted in the following way: a score of 90 means that an organisation is 10% more efficient than the national average, in terms of the outputs of the services and their cost. For further detail sees Department of Health (2004). Source HOSPITAL A's 2007 Integrated Business Plan

> institute working on it, then I started to read books about Toyota, Toyota culture, Toyota system, [how to] take lean manufacturing thinking into service operations. Internally I got more and more convinced that we needed to do something in this area…We needed something that was more sustainable, more long-term, more engaging to front line staff."

Despite his increasing enthusiasm for "Lean Thinking", Peter Dawn's started to construct this idea within the Trust with caution. He believed that it would be very difficult to sustain any big initiative in that direction if the proposal got only lukewarm responses from the senior managers, especially the CEO: "I started to talk with other directors about it, I got a book on it and lent it to couple of people and Jonathan Sheffield was very excited about it." Nevertheless, Peter Dawn's general perception was that some senior managers were still sceptical, though demonstrating partial interest. This perception led Peter Dawn to decide that the safest way to implement Lean Thinking in the Trust would be to start with a very low-key introduction, in order to prove the workability of the concept, and after that advocate for a bigger investment.

However, it was apparent to Peter Dawn that the Trust was ill prepared, in terms of capabilities, to successfully explore and exploit this initiative. At that time, the function of innovation was combined with the general performance management function under the supervision of the Head of Performance Improvement. Peter Dawn feared that when the projects were in operation, the head of performance improvement ended up being overloaded by the current demands of the performance management function and would be unable to give a thorough attention to the projects. Hence, he separated the functions of innovation and performance management by creating the senior post of Head of Innovation. Creating the position of Head of Innovation went hand-in-hand with establishing the Innovation Board to serve as a vehicle of communication and discussion of this issue among the Innovation Team and the Divisions.

By May 2007 Peter Dawn and the innovation team were ready to launch the pilot projects. As Peter Dawn described: "We got some consultancy and decided on some pilot areas, from it we brought in knowledge, KM&T - knowledge management and transfer., [We] chose areas relatively discrete, which we thought we'd have a high

chance of success, and where there was reasonable relationship between doctors and managers...So they weren't too complicated."

All the divisions were asked to submit areas that they thought would benefit from being one of the pilots. Four projects met the criteria desired by Peter Dawn and were included as the first pilots to be implemented (see table 5.1, page 139). In the first year of operation, these projects yielded promising results, especially in terms of productivity, and succeeded in engaging the vast majority of front-line people involved in the projects and in attracting the interest of clinicians and managers from other areas of the Trust. An influential Head of Division described his preliminary evaluation of a project he had been directly involved with as follows:

> "We've got [the procedures in the patient pathway] down from I think 60 or 70 steps to 10 or 12 steps. Massive. Which means that massive change in the way that we've managed it, and what we're seeing now is we're gradually just coming down and down on patient referral. So having been something like 6 or 8 weeks, I think we're now down to 2 weeks. And this has just been a simple sort of change in the way that we book people…This is just the booking process, and I think that's a massive change. And people see that and say "well, it worked for them, it will work for me". And I think it's that sort of infectious sort of belief that we've actually got it now".

Part of the success of the initial phase in the implementation of this new managerial practice was attributed to its capacity to create a buy-in by involving front-line clinicians and employees in the diagnosis, design and implementation of the new processes. As a divisional manager put it:

> "when I first started in this job some of the clinicians said to me… "oh you keep on getting these people coming in with clipboards and telling us we're inefficient…and then they come up with recommendations and then they go away and you know, it happens all the time and we don't think its beneficial." And that is because service improvement isn't something that should be done to people, it should be something that's evolving and interactive. And lean thinking is exactly that, it's involving the people… You know.. getting people more involved in their own destiny, getting them owning the problems, getting

them coming up with the solutions themselves, which is what lean thinking is all about, is just the right way to go".

Table 5.1 – Lean Thinking pilot projects in the HOSPITAL A

Trust's area	Project
Ophthalmology	Introduction of a one-stop minor operation pathway
	Streamline A&E patient flows through developing minor and major pathways
Gynaecology	Introduction of a one-stop diagnostic clinic for women presenting with post-menopausal bleeding or pelvic mass
Paediatric Haematology Oncology	Improve paediatric lymphoma pathway through improving access to theatres and diagnostic tests

In September 2007, Martin Mueller left HOSPITAL A to hold the position of CEO of Guys and St. Thomas Foundation Trust and Peter Dawn was immediately appointed the new Chief Executive of the HOSPITAL A. Despite the excellent results obtained in the last performance rating, Peter Dawn believed that there still is a long way to go in improving the organisation and that "Lean Thinking" will be the key element for the future success of the Trust.

5.7 - Summary

This chapter presented a case of a hospital trust in England that went through a continuous upturn trajectory, locked into early attempts to recover and renew. In the Trust's turnaround trajectory three stages clearly stand out: an initial stage in which the organisation failed to respond effectively to the poor performance (crisis period); an intermediate stage, in which the organisation 'awoke to the need for changes' and introduced some 'short-term' measure to improve its performance to an acceptable level and; a final stage, in which the organisation renewed itself, creating the enabling structure and processes to sustain good performance in the long run.

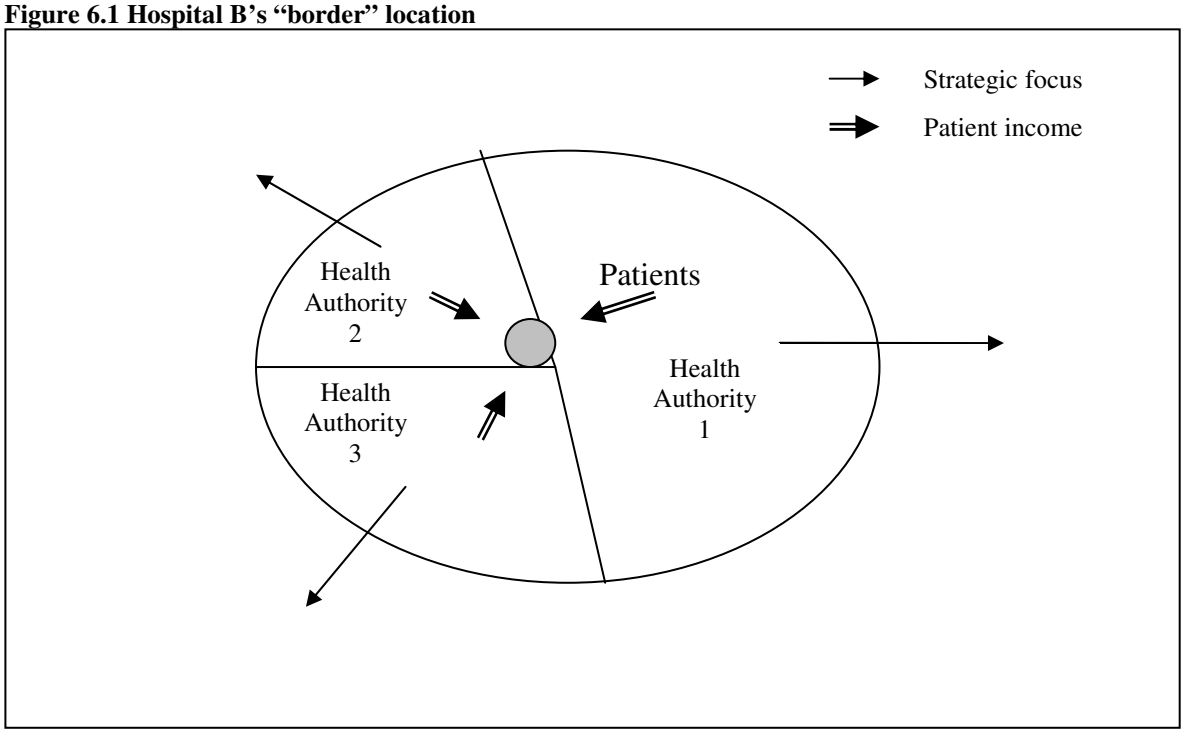
The next chapter – Chapter 6 - will present a case of less successful recovery and renewal attempts. By contrasting the two cases we will discuss how the development, or the absence, of capabilities explains the differences in the success of the recovery and renewal processes.

Chapter 6 - Case Study 2: Hospital B[44]

6.1 – Background

The Hospital B gained Trust status in 1992 during the second wave of creation of acute hospital trusts in England. It was created to provide acute treatment and care for a catchment population of approximately 500,000 people, most of them coming from three health authorities (see picture 6.1), since Hospital B was situated in the fringe of two regions. This peculiar geographic location helped to create what has been called a "frontier culture", i.e. a general sense that the Hospital B did not completely fit into a neat system of healthcare provision of these two regions. Although, this 'frontier' characteristic afforded some degree of strategic autonomy in relation to the health authorities within these regions, it also created some ambiguity about the actual role of the Hospital B within the region.

Figure 6.1 Hospital B's "border" location



[44] The names of the people, who work(ed) in this Trust, used in this chapter are pseudonyms.

Considering the purchaser-provider separation regime, the geographic position of the Trust also meant that the Trust had to face the challenges of negotiating the commissioning of its services with three health authorities, each with different priorities[45]. With the creation of the Primary Care Trusts during the late 90's and early 2000's and the associated devolution of the commissioning to these new entities, the Hospital B ended up with the even more significant challenge of having to negotiate its revenue with 4 PCTs (figure 6.1). In theory, the diversity of purchasers would give some freedom to the Hospital B to negotiate and strategically position itself around a favourable income source, but in practice it meant that the Trust did not have so secure a financial base as a much longer, one-to-one purchaser-provider relationship would afford. Furthermore, as we shall see, the discretion to reposition its strategy around favourable service agreements proved to be very limited, if not inexistent.

The first CEO of the Trust was Jannete Dell, who took over the position in 1993. She was one of the youngest CEOs in the country and was described as a visionary and 'eager' leader, with a strong focus on innovation. During her first 4 years the management of the Trust was running relatively uneventfully, despite some financial problems the Trust had been facing since its inception in 1992 and the need to reduce historical, long waiting lists. During this period, she had a stable management team and managed to build a new hospital on time. However, continuing financial pressure led the Trust to implement in 1997 a major financial recovery plan, resulting in the closure of 72 beds and 400 posts being made redundant[46].

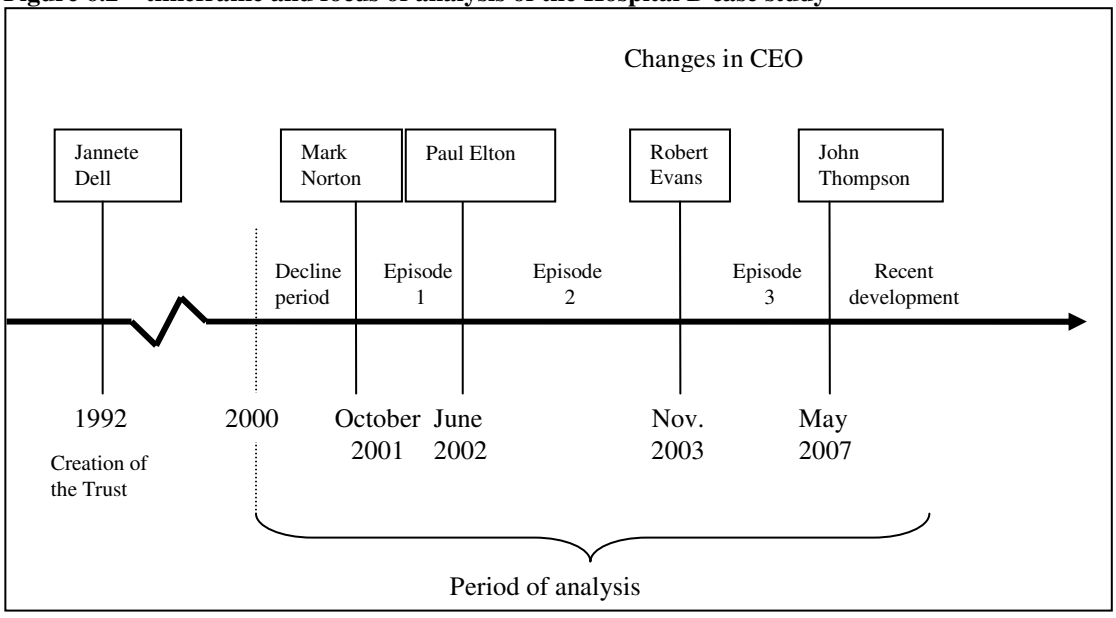
Trust entered the 2000s with a financial deficit and one of the highest waiting-list in the country. When the national performance assessment framework was introduced and the first annual results published in 2001, the Trust figured at the bottom of the performance table, having being assessed as a 'one star'. The situation became aggravated in the subsequent years, with the deterioration of its financial performance and the discovery of a problem with the accuracy and manipulation of performance data, suggesting that the performance of the Trust was, in fact, worse than the information it supplied had shown. In the two financial years that followed the publication of the first performance data, notably 2001/02 and 2002/03, the Trust was assessed as 'zero star' and came under the spotlight of the media as one of the 'worst'

[45] Commission for Health Improvement (2001)
[46] Ibid

hospital Trusts in the country (see table 2.1 at the end of this case). What followed was a period of intense management instability characterized by rapid manager and CEO turnover and a series of CEOs' efforts and initiatives in order to bring about financial and performance recovery.

The timeframe of analysis is the period from 2000 (when the national performance assessment was introduced) to 2007. In order to preserve the authenticity and integrity of the case, we will present a fairly detailed story of the key contextual issues, both internally and externally, shaping the Trust in early 2000s (which we call the 'decline period'), followed by the key episodes in the organisation's attempt to improve its performance and achieve recovery, as well as the resulting success and setbacks of each of these initiatives. Each of these episodic changes was triggered by changes in CEO. There were seven CEOs over this period, including two acting CEOs. We, however, have deliberately focused the analysis on the period of the five CEOs and excluded the acting CEOs since, considering their transient position, they did not have time (nor were expected) to design and implement major changes in the Trust. Schematically, the timeframe and focus of analysis can be represented in the diagram below. As a note of caution, no attempt was made to judge the quality of clinical outcomes over the period of analysis, which, by the way, has been described as being the pride of the people in the organisation[47].

Figure 6.2 – timeframe and focus of analysis of the Hospital B case study



[47] It was often cited as evidence of the quality of clinical care the mortality rate achieved in the Dr.Foster review (see http://www.drfoster.co.uk/hospitalReport/pdfs/hospitalguidefull.pdf) and performance of the paediatric intensive care units, which was described as being at the top quartile in the country.

6.2 - The Decline period: 2000 - 2001

A fear, 'club' culture

The cause of the performance problems in early 2000 was partially attributed by most of the interviewees to the management style of the core executive team that prevailed by early 2000. The core executive team, which many respondents refer to as 'club' or 'the family', was described as a clique of executives and some senior clinicians who kept themselves distant from the rest of the staff and provided support to each other. The rest of staff who did not belong to this 'inner circle' were said to be marginalized from the core executive team. One respondent describe this clique as even having a motto: 'FIFO', meaning "fit in or fuck off". Another respondent added: "if your face didn't fit, you didn't stay…if your face fitted you were in". And again:

> "It [the clique] also included some doctors, a smallish-enough group to be really powerful and it was easy to find out who was in the 'club'. If you walked around the Hospital Bnd if there was a new department you knew they were in the club. If they were still in a 'war-time hub' you knew they weren't in the club"

This style of management had the effect of creating a 'fear' culture among those, especially at the middle level of the organisation, who were not part of the clique. This culture exacerbated the gap between the core executive and the middle level management staff, and prevented the former from the benefit of a 'constructive confrontation'[48] and from a real engagement with the operational problems. One respondent described this fear atmosphere as follows:

> "I can remember seeing middle managers looking very anxious before they went into the Executive team offices down below to talk to them, as if they felt that they would get a hard time. And also they had a concern about one aspect: if they went to another Executive Director they would simply defend their colleague."

[48] This term was used by Jelinek and Schoonhoven (1990) to denote an organisational behaviour which encourages an open debate about problems, thereby enabling the timely generation of new ways and alternatives to handle the problem.

Indeed, the management team behaviour that caused the general climate of fear can be illustrated by a personal experience reported by a middle manager:

> "You couldn't ever easily go to the directors with a problem at that time. If there was a problem it was your fault. And there was too much fear to be able to do it, and I remember once going with a problem with some beds… and I went to the directors and ended up talking to the Chief Executive and I was given an absolute earful - you know there was absolutely no time. It was, 'Go and sort it out, how dare you come and speak to us about a problem? Are you too weak to be able to deal with it?"

Another effect of this fear culture was a remarkable instability at the middle management level. Respondents reported that there was a high level of middle manager turnover. Some managers that did not fit the 'club' either were 'seconded' or left the Trust voluntarily:

> "I couldn't count the number of different management colleagues I have worked with and I know we had a different (name of the specialty) manager for example every year for about 4/5 years. You know I mean managers were just coming and going and if their face didn't fit they left."

Another respondent also remarked:

> "There was an incredible fear culture, I remember working with colleagues in the management team and you'd never know who was going to be there on a Monday morning because people would just be off."

This atmosphere of fear and club culture was also confirmed by a report published by the Commission of Health Improvement in November 2001, which presented a picture of a 'tight-knit' group of core executives in the Trust disconnected from the rest of the organisation. As a consequence, it was reported, 'attention was not always being paid to detail and seeing things through'.

Organisational structure – the 'devolved' clinical villages.

The existing management structure of the Trust in early 2000s had remained largely unchanged since its inception in 1993, although there were some amendments over this period. The structure was said to be quite unique in its arrangements, characterized by a core executive team and board, a middle-level management group reporting to director of operations and 18 devolved clinical directorates. Such a relatively big number of devolved clinical directorates, considering the size of the Trust, was reported as having led to a 'profusion of mini organisations that were not always well co-ordinated and made executive control more difficult'[49].

For each clinical specialty there was a directorate and a clinical director with direct access to the CEO. The intention was "to delegate as much responsibility and authority to the point at which care is actually given"[50]. However, too many devolved organisational units also came at the expense of more effective coordination of the resources and tasks across the organisation. Indeed, the term most respondents used to describe the management structure was 'clinical villages'. Each 'village' operated in relative isolation: "people cope with their bit of their job and the rest of it is someone else's problem, so everyone works in their own little village"[51].

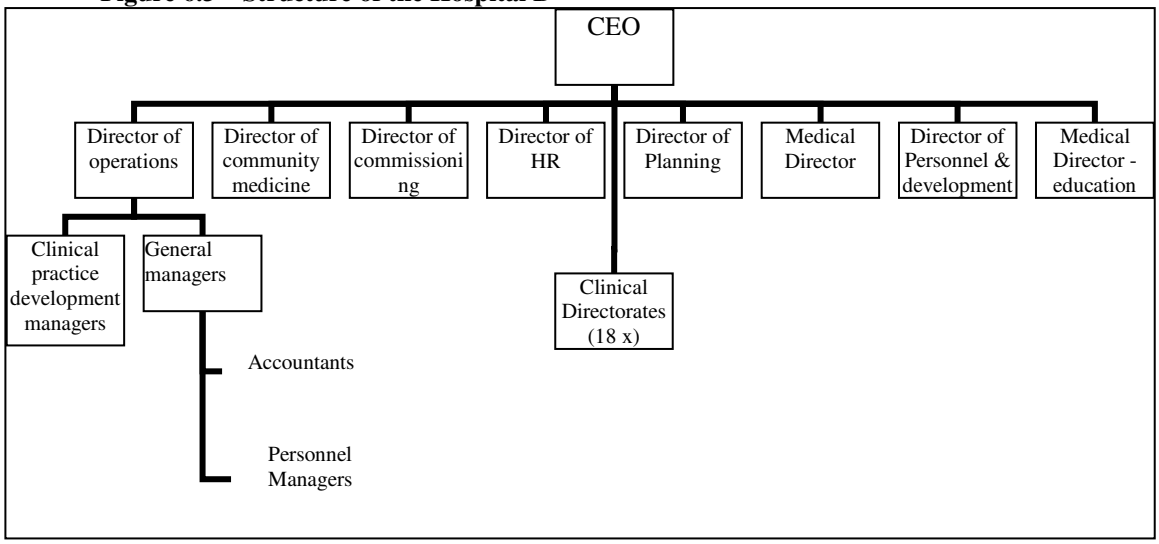
The complex organisational arrangement of 18 devolved directorates and a parallel management structure made it also difficult to establish, in practice, clear lines of accountability and responsibility. It was the general managers who were said to be ultimately responsible for key performance dimensions, especially key targets and finance. The degree of ownership and accountability of the Clinical Directors was described as being variable across the organisation. The 'personalistic' management style adopted by the CEO, based on personal relationships with senior clinical directors was also said to undermine the managers' control over the process for which they were formally responsible. As one former manager put it:

> "On some occasions [the CEO] would agree things with the clinical directors without discussing with the manager who was left in a very difficult position sometimes. One of the problems was that a clinical director would go directly to

[49] CHI (2001)
[50] Source: Progress Report from the Hospital B in implementing the NHS, 28 May 1998.
[51] Interview with a former general manager

the CEO and say something and the CEO would take some action on it without consulting the general manager. And then we would pick up a problem from that, which we actually didn't know anything about."

Figure 6.3 – Structure of the Hospital B



Poor management control arrangements

Controlling the performance of an organisation structured on the basis of a significant number of devolved clinical 'villages' is a significant challenge. Unless there are effective routines and processes in place to monitor, review and respond to performance information, the core executive run the risk of losing control of the performance of the organisation as a corporate entity.

By 1999 the arrangements for performance management of the Trust were said to be working reasonably well, with systematic meetings led by the then Director of Operations to review the performance of the directorates. As one former general manager commented: 'Our Director of Operations met with us, depending on how we were performing, once a month or once a quarter, or once every two months. Depending on if you had difficulties, you had that performance management more often'.

The above mentioned performance management arrangements, however, were said to be dismantled with the departure of the Director of Operations in 1999. A decision was taken not to replace him and the system of regular performance review meetings ceased to exist. As one former manager put it:

> "We had a Director of Operations and he actually performance-managed the Trust on behalf of the Chief Executive. But our Director of Operations left to take up a Chief Executive post and they decided not to replace him. So that's when the Trust started to lose its focus because there was no Director taking responsibility for the performance management across the Trust…And the regular performance management meetings we had just disappeared...The robust performance management that the Director of Operations had done just more or less ceased, and that's when it started to go down hill."

Indeed, a later report on corporate governance commissioned by the Trust in 2002 presented a picture of a Trust in which senior management, in the late 1990s, 'surrendered control of the Trust and allowed events to take their course'[52]. An example of the effect of the lack of centralized control is described by an interviewee as follows:

> "Instead of having, for example, a central outpatients we had something like 20 different outpatient reception areas. And what happened without the performance management at the executive level [was that] all of these outpatient areas went off and did their own thing. So we lost the performance management structure, and people in those areas just went off and ended up making changes to processes without any feedback to the Executives."

Regarding financial control, the Trust adopted a budgeting practice based on the top-down distribution of a percentage slice of the Trust's overall budget to its organisational units. There was no debate nor was there clarity about the allocation of budgetary resources across the organisation. As a consequence, there was little sense of ownership and responsibility for the budgets among the clinicians and managers, who perceived their budgets as an unrealistic financial management instrument.

A more serious problem, nevertheless, was said to be related to the adoption of questionable means of dealing with pressing financial problems and the long waiting-list figures. These involved the use of accountancy and financial management practices to mask the true financial position of the Trust, thereby externalizing an image of the Trust that looked better than it actually was. One of the practices cited was the use of

[52] Hospital B, corporate governance report, by Professor Robert Tinston.

bail-outs provided by external organisations at the end of the financial year to help the Trust to balance the books, or at least, display a less vulnerable situation. A later report on Corporate Governance provided by an external reviewer commented on this situation as follows[53]:

> "The Trust's approach to managing its financial problems can best be accounted for by the coping strategies adopted by large organisations when confronted by large and overwhelming problems. It appears to have been simply too painful and difficult to deal with the financial problems at ward/departmental/directorate level. Instead the Trust appeared to resort to smoothing out and masking the financial difficulties at the most senior level by ever-more questionable means. Paradoxically, the provision of financial bail-outs further undermined the Trust's financial 'grip' by appearing to make apparently major financial difficulties 'disappear'. Budget holders in the Trust became increasingly skeptical about the nature and gravity of the financial problems when the Trust's books were made to balance at the end of each financial year by money provided by external organisations."

A similar situation seemed also to have occurred when the Trust faced pressure regarding its historical waiting-list, of which the information was said to be misrepresented and manipulated to provide a 'false' picture of success against the national target. As a former general manager put it:

> "I remember times when I was working in the waiting list office and it looked like we were going to have a breach of the target, and there was just a huge pressure to change the figure to make it work."

And again:

> "There were things which were bounced around about the waiting lists and the way they'd been managed, with lots of patients who waited longer than were being officially recorded."

[53] Hospital B, corporate governance report, by Professor Robert Tinston.

By mid 2001, however, the problem with waiting lists and financial information had not yet come to the fore. In April 2001, the CEO left the Trust to take a leadership position in another NHS organisation. Gabriel Dodgson , a former Director of the Trust, took over the position of acting CEO while a formal selection procedure was conducted to appoint the new CEO.

6.3 – Attempts to improve the performance of the trust 2002 - 2007

6.3.1 – Mark Norton's period – *blowing the lid off waiting list and financial problem*

In October 2001 Mark Norton, a young Oxford graduate and NHS career manager described as bright, intelligent and very personable, was appointed the new CEO of Hospital B. He had previously worked as Director in Sunderland NHS Trust and Hospital A, but Hospital B would come to be his first Chief Executive appointment. Such an appointment was seen as a major step forward in his career as a young manager in the NHS. Despite the financial and waiting-list problems, Mark Norton, from an external observer perspective, formed an initial impression that the Trust was not out of line with every other trust with a similar 'one-star' performance situation and that overall the Trust had considerable potential for good performance:

> "Externally, we thought there may be some problems but it's got a new hospital, it's got excellent clinical staff, it's got good nursing staff, though there's a real recruitment issue around nurses, but it was largely because of the cost of housing".

Mark Norton entered office trying to take honest stock of the organisation's strengths and weaknesses and, from that, implement his three main priorities: re-establishing the mission of the Trust by 'sticking to the knitting'[54]; improving the performance of the Trust in relation to the two major Targets areas, namely the A&E and elected care services; and establishing a good working relationship with primary care and community services. What followed, however, was a period of intense turbulence, in which the fulfilment of these objectives would prove to be a difficult task.

[54] This expression was coined by Peter and Waterman (1982) to refer to a feature of 'excellent' organisations of focusing their strategies and resources on a few, core activities.

In November 2001, just a few weeks after taking up office, the Trust was badly hit by a highly critical report produced by the then Commission of Health Improvement (CHI) on clinical governance arrangements. The report brought a great deal of negative publicity to the Trust, both locally and nationally. Although the report was based on data collected before his arrival, it was obviously Mark Norton's responsibility to provide an immediate action plan and deal with the consequences of the report. The report also enabled an organisational reflexion on issues of honesty regarding information on waiting-lists and finance provided by the Trust. As Mark Norton took stock of the situation reported by CHI, the stories of waiting lists being fiddled started to be brought to his attention and some 'red flags' regarding the questionable accountancy practices began to be noticed. As a witness recalled:

> "The harder he [Mark Norton] looked, the more difficult the job got. So when he started probing into the finances it looked worse then he'd been led to believe, and when he started looking at the waiting list it looked worse then he been led to believe."

Mark Norton started to feel the paradoxical tension involved in reconciling the need to expend energy dealing with the waiting-list and financial information problem, which was backward looking, and the need to move the organisation forward in order to bring about the desired improvements.

Externally, a report issued by the National Audit Office (NAO) in December 2001, though not referring to the case of Hospital B, had put the issue of waiting-list manipulation in the forefront of public attention. The report revealed that waiting list data had been distorted in nine NHS Trusts between 1996 and 2000. The Department of Health's response was immediate by stating that manipulation was unacceptable and proposing firm actions against managers found to have deliberately distorted waiting figures[55].

Mark Norton had no option but to channel much of his energies to taking stock of the real dimension of the problem and taking disciplinary action with all involved in the problem. His first action was to write a letter to the Chief Executive of the Regional Health Authority with a copy to the Chief Executive of the NHS setting out his concerns

[55] Department of Health 'Waiting list manipulation is unacceptable', press releases, 18 December 2001.

and the potential scale of the problem. A second major initiative was to commission an external review into the Hospital B. The review was undertaken by Alan Bedford and Les Saunders[56] and the work turned out to be much bigger than it had been expected, since the problem continued escalating as the investigation evolved.

During this period, the pressures from the Department of Health and Strategic Health Authority were mounting to the point of sending advisors to monitor the actions taken by the Trust and help it to sort out the situation. This was seen as being very destructive to Mark Norton's authority and freedom to manage the Trust. A respondent described this period as follows:

> "We had high level people from the Department of Health camped in the hospital investigating documents, dossiers, looking at waiting lists...So it was if we were being almost managed like a puppet from the Department of Health and Mark Norton's position became almost impossible. He had advisors sitting in the office next to him so if he opened his door they looked out to see what he was doing. It was just not believable when I think back on those times."

In May 2002, the Bedford and Saunders' review into Hospital B was released and found the following problems: poor systems and lack of leadership; suspended lists being used inappropriately; long-wait breaches not being reported; and that a series of adjustments were made to figures held on prior waiting list figures being reported[57]. As a result, the Chair resigned and disciplinary proceedings with the Director of Finance and the Previous CEO were started[58]. The Director of Finance resigned and the previous CEO was summarily dismissed. The previous CEO later won an action in the Industrial Tribunal for 'unfair dismissal'.

Mark Norton started to feel the pressure from this situation, which was also consuming much of his energy and preventing him from concentrating on the implementation of his key priorities. A witnessed commented:

[56] At the time, Alan Bedford was the CEO of East Sussex, Brighton and Hove Health Authority and Les Saunders was a performance manager of the South East Regional Office.
[57] Department of Health, 'Hospital B Hospital – firm action to be taken to tackle management malpractice', Press releases 3 May 2002.
[58] Ibid.

"The mounting pressure and the worsening position he found he was in meant that every time he wanted to move something forward it actually moved backwards. So it's like each time you say, "I've got a plan to save some money in this area," your new Finance Director who's come in says, "Actually it's worse in that area than you thought so your plans aren't going to be good enough". So we were taking one step forward and two steps back."

To add insult to injury, hundreds of patient referrals that should be on the waiting list, but were not, started to come out of the woodwork. The Trust did not even know whether the patient had had an appointment or any contact whatsoever. The management team then had no option but to expend much energy contacting the patients to understand what had happened. This was described as being not only disconcerting, but also created a backlog of patients that needed to be cleared and with which the Trust was not financially prepared to deal. The Trust was set a timescale by the SHA to clear this backlog and to reduce the existing waiting-list. The remedy included the use of private sector hospitals without, however, any extra funding for this. Mark Norton felt that he had no option but to agree, though not formally, with this settlement as a way to achieve some progress on the waiting-list, despite its impact on the already adverse financial situation of the Trust.

The pressures and demands that came from the investigations just kept mounting. Most of the executive team had been suspended or were responding to disciplinary investigation, for different reasons. In such a turbulent situation, he was not able to assemble a strong and stable executive team. Quite the contrary, since his arrival in October 2001 he had to rely in most of the cases only on interim directors. By June 2002, only 8 months after his arrival, he had already had three financial directors.

For a young manager in his first time CEO appointment, the mounting pressure had proven to be too much for him. The last straw was when he also had to suspend the medical director, one of his closest allies in the Trust, under the allegation of abusing private practice. He believed he did not have sufficient senior leadership experience to be in effect a one-man band. He then negotiated his exit with the Regional Office of the Department of Health in a way that he could go on and do other things somewhere else, and someone with more senior experience could come in. He left the Trust in June 2002 to work on special projects for the Department of Health. In the same month, Paul

Elton, an experienced NHS CEO, with a track record of turning 'failing' organisations around, was appointed the Trust's new CEO.

6.3.2 – Paul Elton – *a processes re-engineering era*

Paul Elton was seconded from Hospital Z to Hospital B for an initial period of six months. Having built a reputation as a turnaround specialist, Paul Elton was headhunted by the Regional Director of the Department of Health to bring about a fast turnaround of the Hospital B's performance. When Paul Elton entered office, he perceived that the Trust was starting to suffer the aftermath of the waiting-list reporting crisis: there was national and local media interest in the Hospital B, accompanied by negative publicity; the Trust's staff morale was described as appalling; the performance of the Trust against the key targets was far from satisfactory; and the financial deficit had substantially increased, mainly due to the arrangements that had been made to catch up on the backlog of patients in waiting-list.

After three weeks in office, he formed the conviction that the organisation structure based on highly devolved clinical 'villages' was not adequate to tackle the Trust's immense performance problem: "In that case, devolved managerial villages meant no control. People did as they liked or didn't". He strongly believed that he needed to change the structure of the organisation to one that was based on the process of delivery, rather than on isolated, devolved clinical directorates. Due to the crisis context in which the Trust was immersed, he believed that he needed to implement the changes instantly:

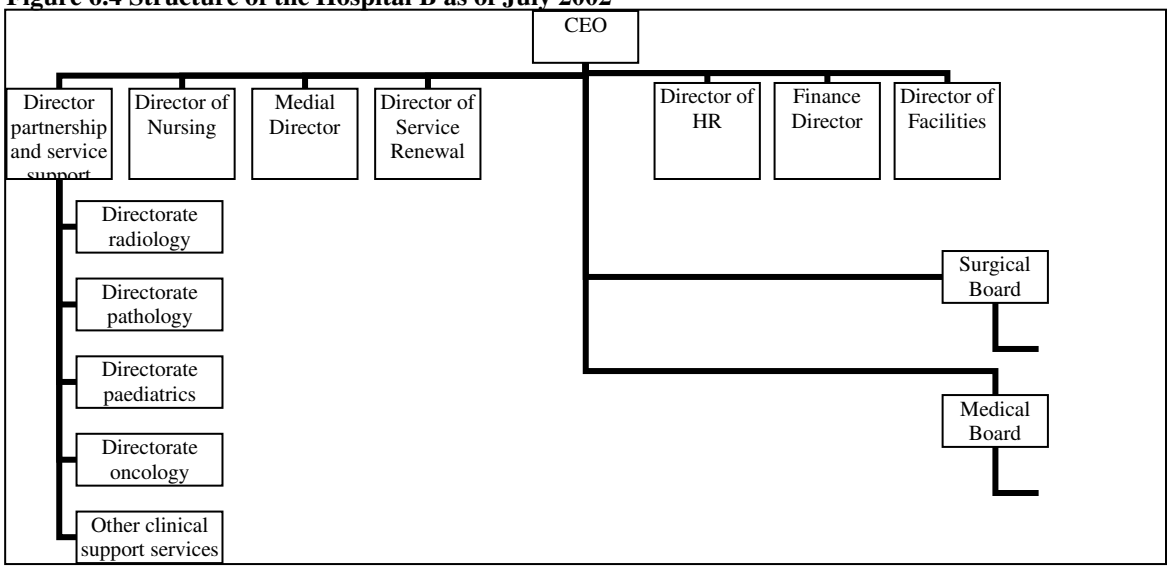
> "I went home one weekend, wrote down what I wanted to do and came back next week and started having meetings with people, saying, "This needs to change. I am going to change it now. And it should be a 3 months consultation but we need to act now. But if you disagree with me I won't do it". And I said this at my first meeting with staff. There was a big silence and then someone said, "No, it's been messed-up for too long. Just do it". And then people round the room said, "Yeah, just do it please"."

Deriving from his experience in Hospital Z, Paul had realised that poor performance was in most cases associated with poor processes to deliver the

organisation's core activities. Hence his strategy to deliver a relatively quick turnaround in Hospital B was based on four interconnected tenets. The first tenet was to organise the Trust around its core processes, notably the medical and surgical processes, as opposed to the traditional functional and devolved clinical units. The second consisted in intense use of process design and re-engineering techniques. The third involved empowering the performance delivery groups associated with the Trust's key processes. The fourth was the use of frequent performance review meetings.

To implement the first tenet, Paul Elton started by re-organising the structure around the Trust's core processes, reflecting the Trust's key performance pressure. At that time the Trust's major performance pressures were the Accident and Emergency, which was dealt with by the medical specialities, and elective patient waits, which was handled by the surgical specialties. Thus Paul Elton created a new structure that brought together the entire medical and all the surgical specialties within a single medical and a single surgical group, respectively. Each of these groups would be headed by a board, chaired by a physician or surgeon, respectively, and formed by clinicians and managers. The other four remaining directorates that did not fit in these divisions, namely Radiology, Pathology, Paediatrics, and Oncology, were brought together as the Clinical Support Group with services such as pharmacy and therapies . So now there were three key groups instead of about 30. The structure of the organisation is represented in the figure 6.4.

Figure 6.4 Structure of the Hospital B as of July 2002[59]



[59] This is a simplified version of the Trust structure, drawn from interview and board documents.

The second tenet consisted in the use of process redesign as a technique to improve the delivery of the core services of each groups. In a nutshell, process redesign techniques involve mapping the process, and identifying and addressing the key constraints or 'bottlenecks' that prevent the process from achieving better results[60]. Paul Elton was convinced that by bringing this technique the team groups could tackle the main problems that were affecting the achievement of their performance targets. What drove Paul Elton's conviction was his knowledge of process redesign and his experience in using this technique in his previous job at Hospital Z: "I'd done it and I knew how to do it because I was the first person who used 'lean' in the UK in the health care…so I knew that bringing those techniques of process redesign we could tackle the problems because I'd done it and it has worked in an area where I wasn't sure in Hospital Z."

Paul Elton also knew that it was necessary to bring in the skills and competences needed to apply the process redesign techniques. So, he brought with him a Director from Hospital Z, Hermione Fulljames, who had undertaken fundamental process re-design work there and whom he regarded as a 'brilliant implementer' of process redesign techniques. She was appointed as Director of Service Renewal and her function was to facilitate the groups to do the redesign and bring in the skills and competencies to review and design the process.

The third tenet was empowerment. Paul Elton wanted the processes to be redesigned on the basis of what the groups' participants understood, rather than having it imposed top-down on them. Thus, he deliberately decided not to chair the groups' meetings and empowered them by sending a clear message that he would provide support to implement their change proposals. As Paul Elton recalled:

> "I attended [the meetings] but I didn't Chair them, and the purpose of attending them was to say, 'You are leading on this, but I am involved. I will listen and if you need help to make things happen I will make them happen…' So as much as anything I was providing, either directly or indirectly, insight into how to do it and empowerment."

[60] A famous process design theory is the 'theory of constraints', popularized by Goldratt and Fox (1989) *The Goal: A process of ongoing improvement*. Gower, Aldershot.

Finally, the fourth tenet dictated the dynamics of working for the groups. It consisted of an intensive performance management approach exemplified by one-hour weekly meetings, starting every Friday at 8:00 am, where group members discussed performance and process data, proposed corrective actions and set targets for themselves for the next week's meeting. For the surgical care group this meeting was called the 'do or die' meeting (a title that had originated at Hospital Z). As Paul Elton described, participants in the 'do or die' meetings were charged to work along the following lines:

> "We would set ourselves goals in terms of what we needed to understand on data; once we got the data, what we needed to do about processes to improve them, and what were the outcomes in terms of targets as a result of that and using it to feed back on each of them. And if the targets weren't coming we'd ask ourselves, were the processes still wrong? And if we weren't sure then we'd go back and say, 'Are we collecting all the data we needed to?' And when we'd done we'd go back and say, 'Ok, what's that doing to the process? Can we now redesign the process?' Then look at the outcome, 'Is that giving us the outcome we want?' [So it is all about] information, process and outcomes."

These four tenets shaped the management approach that Paul Elton implemented to improve the Trust's performance against the key targets. Some bottlenecks were identified and addressed, either by a new process redesign or increasing capacity by opening more beds. The results, in terms of performance against the key national targets were substantial, leading the Trust to achieve significant progress, by the end of the financial year (March 2003), against the key national standards (see table 6.1). However, the poor performance in the first quarter of the 2002/03 financial year, plus the increasing financial deficit, meant that the Trust was inevitably heading toward another 'zero star' for the 2002/03 national performance ratings.

Table 6.1. Progress toward meeting targets during Paul Elton period

		Paul Elton's period			
	Q1 2002/03	Q2 2002/03	Q3 2002/03	Q4 2002/03	Full year 2002/03
Outpatient waiting longer than standard	42	7	0	0	49
Inpatient waiting longer than standard	556	15	0	0	571
Number of patients waiting > 12 hours in A&E (in year target)	80	6	0	1	87
% patients waiting less than 4 hours in A&E (year end target: 90%)	45.4%	42.4%	67.8%	76.5%	76.5%

Source: Hospital B Annual Report 2002 - 2003

Clashes with key external stakeholders

Owing in great part to the backlog of patient referrals that came out of the woodwork and the pressure to reduce waiting-lists by sending patients to a private sector hospital, the Strategic Health Authority had planned a deficit of £17 m for the health economy of the region of Hospital B for the 2002/03 financial year. This was partially attributed to the extra work costing several million pounds that had to be outsourced to private sector hospitals in order to catch up on the backlog and the pressure on the waiting-list, and for which no extra funding was provided.

Among the Strategic Health Authority and the commissioners there was a firm position that this backlog was the responsibility of the Hospital B and thus it had to reduce it with no extra money. The Trust was clear that it had not been funded for the backlog. Paul Elton believed that the Trust could not and should not pay this bill. He formed the conviction that an impossible financial settlement had been attempted to be imposed on the Trust just prior to his arrival. He decided to challenge this.

> "I wouldn't accept that it was all the Hospital B's fault. And in particular I said to the PCTs, "You've got to take some of this debt, some of it is yours", and we also implicitly said to the Health Authority, "This is not an accurate account of the way things are", and that was very, very difficult."

On the national front, following the publication of the 2001 national ratings, the region of Hospital B was considered as "a basket case", since three out of the nine 'zero

star' Trusts were part of that region. Alan Milburn, the then Secretary of State for Health, then decided to put into operation the government policy to respond to poor performance. The first was to replace the leadership of the SHA. This was accomplished with the appointment of Jackson Cameron at the end of 2002 as the CEO of the SHA - as described in the previous case study.

Secondly, Alan Millburn was bound and determined to carry forward the government policy of franchising all 'zero star' Trusts. The franchising policy dictated that management of the Trust would be outsourced to the private sector. Yet Paul Elton was also encouraged by the then Secretary of State to put in a bid. However, Paul Elton personally felt that the targets imposed by the government for the bid were unrealistic. He and his team decided to put forward what they thought would be a realistic proposal, highlighting what they considered could be done and what they thought would be unachievable. However, in the run-up to the franchising, Paul Elton's proposal was said to be too unrealistic and thus undesirable in the process. He found this deeply disappointing:

> "We were told that our franchise wasn't wanted, which was really hard because we knew we could do all that needed to be done and we had a track record…[This] was quite demoralising for us because we'd turned the place around…But because we'd had the nerve to say 'The emperor has no clothes', we were regarded as not being loyal and I think at that point it was clear that my tenure was going to come to an end."

The franchising process eventually collapsed in April 2003. However, it was by then clear that the context had changed into the new approach of the SHA, and Paul Elton decided in the same month to end his secondment and rather than return to Hospital Z take up an offer to act as a roving turnaround CEO across South East England. Together with Paul Elton most of his executive team also left the Trust, including the Finance Director, the HR Director and the Director of Service Renewal. The performance management approach he introduced was thus dismantled. After he left Christine Thompson, one of his Directors, was appointed Acting CEO of the Trust.

6.3.3 – Robert Evans – *stabilizing management team and securing financial balance*

As part of the changes in leadership which Jackson Cameron was implementing to solve the performance problem of the 'failing' trusts that were under the remit of the Strategic Health Authority, Robert Evans was appointed the new CEO of Hospital B in November 2003. Robert Evans had a strong reputation as a successful NHS chief executive and was described as being very personable, yet very straight and tough in his leadership style.

Despite some progress in the performance management processes, Robert Evans inherited a Trust which was in a managerial turmoil. He was the sixth CEO and the Trust had already had seven financial directors in less than 3 years. In terms of performance targets, the Trust was under pressure from many angles. The outpatient waiting-time target had become tougher and tougher, dropping from 26 weeks in the beginning of 2002 to 21 weeks in March 2003 and down to 17 weeks by the end of 2003/04 financial year. The latest performance rating published in July 2003 had placed the Hospital B in the media headlines as one of the 'worst trusts in the country' for the second consecutive year. Furthermore, the Trust ended up the previous financial year with a financial position showing a record annual deficit of approximately £ 25 million and an accumulated deficit reaching £ 43 million, which needed to be recovered[61]. On the external front, the relationship with key stakeholders, notably the PCTs, was described as being shot to pieces.

The effect of the managerial turmoil, especially following the continuous and fast changes in CEO and Financial Directors was said to be twofold. Firstly, the organisation was not able to fully understand and control the finances of the Trust. As a respondent remarked:

> "Nobody understood what was going on, nobody understood the income and expenditure…There was no understanding about actually what the budgets look like, how much money was actually really being lost, how much income was being received or whether we were not getting all the income we actually even deserved."

[61] Including the deficits prior the 2002/03 financial year.

Secondly, the turmoil in the management board had also the effect of undermining the clinicians' engagement with the managerial agenda. The reaction of clinicians to this management turmoil was, quite understandably, to become introspective and to beaver away at their own clinical specialties in order to keep the services going. As an influential director put it:

> "There was a period where they (the clinicians) didn't know who the Execs were or hadn't even seen them. They (the Execs) had been in the Trust a short period of time, some of them were living in rented flats whilst they still went home to other parts of the country for weekends. It had a feeling of great impermanence and instability."

And again,

> "It was very difficult to affect clinical engagement. I mean if you asked a clinical director and said, 'Look at your finances and make savings', if the Finance Director is lasting on average two months, it's really difficult to engage with that. So the instability in the Executive team made clinical engagement very difficult for that period…And I think what people did was went back to their departments and said "The finances are in a mess, the waiting lists are enormous, we've just got to do the best we can to keep the show running"."

Filling the managerial vacuum

Robert Evans believed that without the support of a strong and stable management team he would not be able to meet the immense challenge involved in bringing about financial and operational recovery. It became apparent to Robert Evans from the outset that the Trust did not have the managerial capability needed to recover the organisation's performance. He identified three main gaps in the management team: the absence of a permanent Director of Finance, a Director of Human Resources and a Director of Strategy and Planning. There was no director to perform the function of strategy and planning, there was no director of Human Resources, and the position of financial director was at that time developed by an acting director of finance who had been employed by the Trust on a short term contract via a third party.

Robert Evans' first initiative was thus to fill the gaps in the management team. He knew, however, that the organisation had gone through too much instability and could not stand another period of turmoil in the management team. Accordingly, he wanted his term to be marked by stability. As an executive director commented:

> "He made it very clear that he wanted to stay for 5 years, although he didn't stay for quite that long. He also made it a condition that he got a permanent executive team and he insisted that any executive coming in would move to [the city of Hospital B] and people would not commute long distances and go home for weekends because he wanted the message that we would be stable."

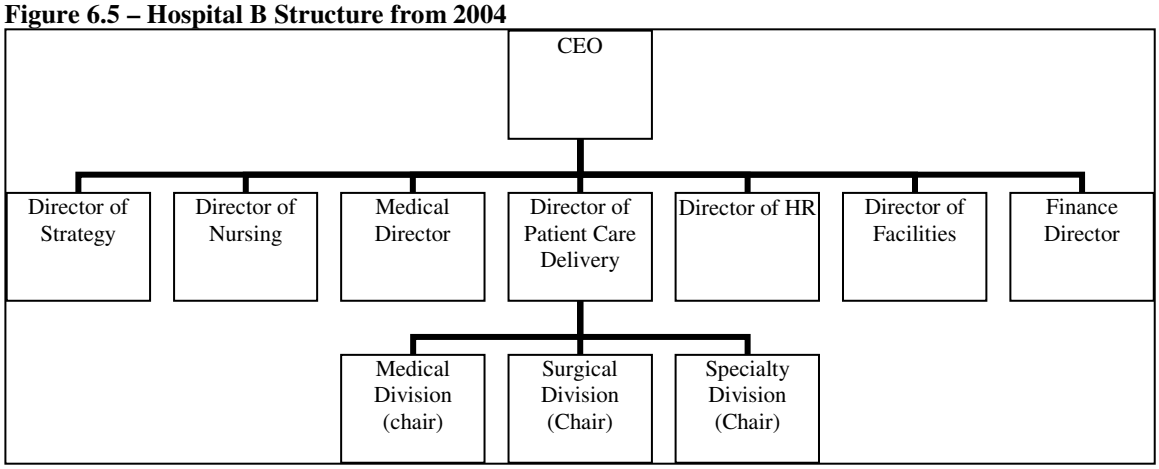
Due to the financial pressure the Trust was facing, Robert Evans felt that he had no option but to work massively hard at savings in order to gain the financial credibility that would enable him to move the Trust forward. Accordingly, he believed that it was absolutely crucial at that particular situation to have a very strong and experienced financial director. He then recruited Jake Russell, an experienced financial director with a track record in financial recovery and whose management style was described as being very tough and straight:

> "One of the first things I did was to recruit Jake Russell as a Director of Finance because actually the most important thing for me was to stop the bleeding, stop [the growing financial deficits]….I knew lots of people who had worked for me in my previous Chief Executive roles, but I recruited Jake because I wanted a particular sort of individual [for the position of director of finance]. There were horses for courses, really, and Jake is a very tough individual, he's systems oriented and I knew I could rely on him to get the money out of the system."

The gaps in management team started then to be filled. He recruited a Director of Planning and Strategy in March 2004 from a Trust he had worked at in Kent. By July of the same year, with the appointment of the HR Director, he had already completed what turned out to be the most stable management team since 2000. He also made some minor adjustment in the structure, notably by renaming the medical and surgical boards "medical and surgical divisions," respectively, and grouping all other directorates into another division called "specialty division". All the divisions were made directly

accountable to the Director of Patient Care Delivery (former director of operation post). The new, adjusted structure is represented in the diagram below.

Figure 6.5 – Hospital B Structure from 2004



Tackling the financial management problem: setting out a recovery plan

As the executive team stabilised, Robert Evans was ready to launch an intensive effort to recover the Trust's finances. Some spadework had already been done, as Robert Evans and Jake Russell had built up the capacity of the financial management division. This was done basically by bringing key people into the financial division and putting pressure to leave on existing staff that they thought were not delivering. Jake Russell was then able to build a team which was described as strong and extremely loyal to him. Jake Russell also persuaded Robert Evans to re-house the finance team, by moving it from poor accommodation in the hospital to a refurbished and redecorated block. Such a change was viewed as having the symbolic effect of demonstrating the importance the Trust would attach to its financial team.

Robert Evans' and Jake Russell' plan to recover the Trust's finances included massive work on both cost and income fronts. From the outset they shared a conviction that in order to achieve financial recovery, four activities needed to be effectively and concurrently performed: making sense of the Trust's financial situation and setting out a tough, though realistic, recovery plan; putting into practice effective financial control processes; fostering a culture of cost management, in order to secure engagement with, and overcome resistance to, cost-cutting and retrenching measures; and managing externally in order to re-negotiate more realistic and favourable contracts with purchasers.

The Trust forecast a considerable financial pressure for the 2004/05 financial year, with some projection showing a baseline deficit of £20 million, out of which only £9.3 m would be met by means of the NHS Bank support. An additional saving of approximately £11.4 m was thus required if the Trust was to meet its financial pressures. At that time, however, there was not sufficient reliable information about the real cost of the organisation's services that could be used as a basis to identify potential saving targets. Traditionally, the Trust adopted the financial control practice of budgeting on a roll-over basis, in which the financial resources allocated to the organisation's unit in a year were simply what they got in the previous year plus inflation. Over time, the budged was said to have become out dated and unrealistic, thereby undermining its credibility as an effective financial control instrument. When asked about how the budget had been formulated prior to 2004, a former senior manager answered:

> "There wasn't one. Not one that anyone would admit to, sign-up to, or guarantee. So there was just that huge piece of work that just said, "You might not like it, it might not be enough but this is what you're got to work with." And so that was a sort of starting platform, really."

Another former senior manager added;

> "People were not interested in controlling budgets - no financial control. No concern for finance, no credibility of the finance staff, no belief in the finance systems and therefore no financial control, a downward spiral."

The elaboration of the recovery plan, thus, went hand in hand with a 'bottom up' budget-setting exercise that could provide a more realistic basis to support and underpin the recovery plan. The bottom up budget-setting exercise was then the Trust's first attempt to get a better understanding of how the Trust's money had been spent and a more realistic allocation of the Trusts resources. The exercise was undertaken during the first months of 2004 and involved gathering information about the services and financial pressures of approximately 400 budget-holders. Based on this information, the Financial Recovery Plan was presented and approved by the Board at the meeting held on 19th March 2004, identifying a saving target of approximately £11.4 m in cost reduction and additional income.

A draft of the budget was presented to the Board in the March and April meetings and the final budget was presented and approved in May 2004. The savings targets identified in the Financial Recovery Plan were then included in the Budgets that were allocated to the organisation's units.

Executing 'interactive' budgetary control

For Jake Russell, having the basic control instrument in place was a necessary condition for attaining financial control, but not all that was required. It was above all necessary to make it work, i.e. to put it into practice. To do so, Jake Russell believed two tasks still had to be done: making sure that the budget-holders really understood their budgets, saving targets and the underlying assumptions behind the figures; and creating incentives (sanctions) for budgetary performance:

> "For me it's about establishing the basic control, making sure the Executive team downwards really understand what they've got to do and stay together on it, make it simple for everybody to do it with a budget and have a clear series of 'threats', which is not a good word but [it means that] if you don't do it [you must] understand the consequences."

To make sure that the budget-holders really understood the budget and the assumptions involved in its calculation, Jake Russell adopted an interactive, and to a certain extent 'Socratic'[62], approach to the budgetary execution control. He established a regular and interactive process of monitoring the execution of the budgets. Every month, he required that the accountants monitor the budget's execution and visit the budget-holders to feed them back and help them to understand their budgets and, when things went wrong, find out what had happened, correct it or agree on corrective actions with that individual.

> "We'd send somebody out, we'd take you through it line by line on who it was, you'd know how many of that grade of people, what they're budgeted for, the level of overtime. Everything… So you knew exactly what you'd got to spend within that budget. You knew what it contained and you know how to go about

[62] I borrowed this term from Barzelay and Thompson (2003) to refer to a pedagogic approach in which the interaction between the finance team and the budget-holders provided also an opportunity for teaching and learning.

it. You've also got the name of someone there who comes out to see you every month: 'How's your budget going?', and you can say, 'I've got a problem,' or, 'I haven't got a problem'. [This] makes you feel at least it's happening and lo and behold you'll control that budget because you've got someone guiding you through it and its easier to do that than keep having an argument every month... It's much easier to actually do what they're asking you and we'll show you how to do it, and that's what we do. It's a very simple process and it works."

With this interactive process in operation the financial team was able to implement a timely and effective control of the budget's execution across the diverse units and hierarchical layers of the organisation. No budget-holder could possibly keep overspending without the financial team having noticed and acted to understand and sort out the problem together with the budget-holder. As a former financial manager illustrated:

"We had one budget that just kept overspending and overspending and in the end Jake and I sat them down and said, 'What are you doing?' Because we couldn't get any sense out of our teams. And then we found out that they hadn't sorted out their new prices. So we got an order raised, sorted out the new prices problem and went off."

The other mechanism Jake Russell activated to make the budget control work in practice was the introduction of incentives for budget performance. Such incentives, however, did not come in the form of traditional monetary awards or bonuses. Rather, they came in the form of 'threats'. It involved making key people accountable for the budget performance and sending a clear message that things for them could change for the worse if they did not comply with the budget execution requirements. As a former director explained:

"He [the CEO] has been quite clear about [accountability], 'Managing is part of your job; if you don't want to do your job then we need to get someone who will do that job'. A quite clear threat, end of game. You don't end up having to sack people for the most part, you've just got to have the threat there and because in the last three years Robert had sacked people as I had through the organisation quite a lot, they know you mean it. Therefore there is accountability."

This attribution of threat also involved the manipulation of possible adverse scenarios to make influential clinicians realize that important collective values for them will no longer be satisfied unless they adapt their behaviour to the perceived situation. The collective values involved the existence of the hospital in its current format, including its existing portfolio of clinical specialties. The adverse scenario refers to the existing debate around the adequacy and feasibility of having a hospital in the city offering expensive and complex medical specialties. The 'threat', thus, comes with the message that the adverse scenario is plausible if they in the Trust do not comply with the current situation, which imposes a compliance with the proposed, tough budgetary control. As Robert Evans put it:

> "I did use threat of closure, really. I suppose to say, 'You know this is the last chance saloon and if we don't sort this out there won't be the Hospital B that you currently know because services will go.' And I used a bit of the threat of Hospital A or the Health Authority...and I wasn't particularly unsettling, but to say that's the reality of life."

A former director also commented:

> "So by going out and talking to these people [influential clinicians] which Mark did a lot of, a huge amount, effectively he gained their support because he was up front about what we had to do, and quite simply it's, 'have you thought about what the alternative is?' which was effectively dismantling the hospital in its present format, most of the good stuff going over to Hospital A and Hospital B just dropping down in medical scale. And that would be very bad; it ruins their careers, their private work, ruins everything."

On the board front, Robert Evans believed that to reinforce the cost control culture in the organisation his and his executive team's behaviour should be consistent with the priorities the Trust attached to cost containment. He believed that direct involvement of the CEO and the finance director with the cost containment effort of the Trust would not only have a practical effect, but also a symbolic one. He described his behaviour as follows:

> "The cost improvement programme was 90% sort of sweat and graft and 10% sort of inspirational. We worked relentlessly, Jake and I've been into organisations where there's a lot of words around 'targets are important and money is important', but the 'videos' didn't match the 'audio'… We made sure that our behaviour [matched our speech]. Jake and I, we would spend hours in meetings going line by line through people's budgets."

As part of the Trust's effort to control its expenditure and foster a business-like culture in the provision of the services across the organisation, Robert Evans introduced more rigour and discipline in the planning and decision-making processes, particularly those that involved big investments and developments. The idea was to improve the quality of the decisions that had a high impact on the Trust finance, by making decision-makers understand their impact in terms of cost, potential for income generation and trends in the health context. Once in office, Robert Evans realized that important decisions, often with a great impact on Trust finance, were not by then preceded by rigorous planning and business case. Hence, one of the Robert Evans early initiatives was to introduce a more rigorous approach to business case as a requirement before making decisions about any big development. As he described it:

> "In my first week, a consultant knocked on the door and said, 'I need a new [medical specialist], is that ok?' I go, 'Have you written a business case?' He goes, 'What is a business case?'. He said in the previous regimes the CEO just used to say, 'Yeah'. I said, 'Well it's changed'. And so I introduced the concept of business case."

An influential director also complemented:

> "When we first moved into this sort of mode of working the first few business cases were smashed because they just weren't tight enough and I think people got a little hurt because they submitted what they thought was a [fair request]. For example, a consultant's retiring and we need to replace him and they said, 'Oh we need a replacement because we've always had 6 people so we need the 6th person to complement', 'Go away, give us numbers, give us the finances. Tell us how much it cost; tell us what income they generate. Tell us what new

service developments you anticipate in the next 5 or 10 years in that area and whether we do need that consultant.'"

Securing engagement and overcoming potential resistance.

Robert Evans anticipated that he would have a hard time and face potential opposition or resistance from influential clinicians who might become upset by a tough budgetary-control regime. However he believed that he could overcome resistance and get engagement from influential clinicians by adopting three key principles, apart from the threat element above mentioned: more transparency and equity in the decision-making processes, brought about with the introduction of the business case discipline; intense communication and interaction processes with influential people in the organisation; and involvement of key clinicians in the development of a long-term vision and strategy for the Trust.

Robert Evans believed that paradoxically the introduction of more rigour in the business case process, although upsetting some influential clinicians in the first instance, would serve to send a positive message to key clinicians that their requests would be treated with fairness, equity and transparency. He expected that the clinicians would accept the business case discipline because they would rather prefer to work on the basis of more transparent decision-making rules than to go back to the old 'club' culture that prevailed in the Trust in the early 2000s. As Robert Evans recalled:

"I said [to key clinicians], 'In my regime here I won't have favourites, I won't have cliques, I won't have little clubs, I will treat everyone the same and that is on the basis of the case that you put to the board'… and we will judge things appropriately and you will have feedback. And if it's a "No" you will have a "No because..."""

Another measure Robert Evans and Jake Russell employed to overcome potential resistance and secure engagement was communication. They wanted to establish an effective communication mechanism with influential clinicians, by which they could have an honest and transparent conversation about the Trust's situation and priorities and respond to the clinicians' concerns and doubts. Both Robert Evans and Jake Russell were described as being individulas who were very straight and transparent

with people in the organisation. Robert Evans, in particular, was described as being a very personable and charismatic leader. He and Jake Russell attached special importance to, and spent a great deal of time, listening and talking to people in the organisation. They did this by both participating in formal meetings and walking around the Hospital, where they had more informal chats with influential clinicians. Jake Russell described his communication practice as follows:

> "My practice as an individual is to walk around the hospital, talk to people all the time, go onto each ward and talk to the nurses; go out and talk to the doctors, go and stand in theatres and talk to the doctors. I'd spend if I could half a day every month going out and working with the people whether they're porters, in pathology whatever so you get seen. And you're telling your story to everybody. Go and talk to the Unions, tell them exactly what you're doing and be honest about it. People don't like it; they don't like being cut down but they understood the necessity for it. And actually it was accepted."

An influential clinician described Robert Evans communication style and its effect on overcoming potential resistance among clinicians as follows:

> "He got on extremely well with clinicians. He was very personable, had a very, very easy style yet was very experienced and very tough. [If he disagreed] with something, even if people came and pleaded, he'd say, 'I understand why you're pleading, and you've got to understand why I'm saying no', and people respected him for being very straight. He never dodged an issue or pretended he didn't know, he would be honest and say, 'Look here is the true position; this is what we have to do'. So I think he was very well liked."

In the same vein, a former general manager commented:

> "Robert is very charismatic; he's the only man I've ever seen take a really negative message into an open staff meeting which was about people potentially being made redundant and he ended up with people clapping and almost cheering. Mark had tremendous ability to give you a message that was to you and you really heard it and felt it. And he had a great ability to influence people,

you know Mark didn't raise his voice very often and he didn't swear very often, but he influenced people."

The third measure that Robert Evans introduced to get clinicians on board had an educational character. With the help of the Medical Director, he created the Clinical Leadership Programme, an educational event running on a regular basis, where senior clinicians get together to acquire management knowledge and leadership skills. Since Robert Evans wanted to encourage the participation and involvement of clinicians in the programme, he decided that the programme should be designed by the clinicians for themselves and he would just provide the facilities and support. These events were seen as having the practical effect of not only providing the skills and knowledge senior clinicians would need to run their units, but also developing a common language between managers and clinicians that would help to bridge the gap between them.

Managing externally

When Robert Evans came into office he realized that there were two extreme views about the causes of the Trust's financial problem. According to Robert Evans, from the Trust's point of view the causes of the problem resided somewhere else outside. People inside the Trust believed that the problem was so big that they could not actually do anything about it and, therefore, the solution should come from outside. Conversely, from the external stakeholders' perspective, notably the commissioners, the cause of the problem was the inefficiency of the Trust. For Robert Evans, however, neither of these positions was completely right:

"They were both extreme, and the answer like a lot of things is somewhere in the middle because the Trust did need to become more efficient, but also the PCTs needed to move in terms of their own conditioning patterns because actually this problem was so big that curing inefficiency, as they suggested, wouldn't save us."

This perception led Robert Evans to dedicate much of his energy to sell key stakeholders, particularly the commissioners and the Strategic Health Authority, the idea that the solution of the problem would require the efforts of both parties. For the

part of the commissioners, this effort would involve the recognition that the Trust had not been properly paid for the services it provided. Such a realisation, unfortunately, was not simple and took longer than Robert Evans expected, for different reasons.

Firstly, just after one year in office, he lacked a crucial support from the Strategic Health Authority. Jackson Cameron, the then CEO of the SHA who appointed and gave support to him, was tragically killed in a car accident. Robert Evans did not get on personally with Jackson Cameron's successor, leading to deterioration in his relationship with the SHA. Secondly, as described in the introduction of this case, the Hospital B had always to deal with four PCTs, each with different priorities, and was not able to build a more effective relationship, based on a cohesive strategy, that a more long-term relationship with fewer commissioners could afford. Finally, for Robert Evans, there was a climate of suspicion among the commissions, which blamed the Hospital B's own management inefficiency solely for its financial trouble and were said to be reluctant to provide the extra income demanded by the Trust. As Robert Evans remarked:

> "Getting the debate and getting a realisation of that [the problem was not only Hospital B fault] was something that took a lot longer and was more deep rooted than I ever imagined…We got into a big row with the PCT's because they were saying, 'Well you're treating the same patients and suddenly you're asking us for x million more income', and I was saying, 'Well it's because we haven't been asking you for enough. So we're not asking you for more, we're just asking what we think is legitimate.'"

Robert Evans was convinced that the Trust had not been properly paid for the services it provided. This conviction led him with only two options: stop providing services for which the Trust had not been paid, or re-negotiate a proper payment for these services. Due to the nature of the services provided the first option was soon proven to be virtually unattainable. As a former director explained:

> "Anytime we tried to get out of anything the Primary Care Trust would take us to the Overview and Scrutiny Committee. For example, we were providing a service to some disabled children, very emotive, from which we got no payment, none at all. So we said, 'We're going to stop this', and then they took us to the

> Overview and Scrutiny Committee and prevented us making a lot of the saving… Frustration was off the scale."

Robert Evans insisted in this line of negotiation with the PCTs and eventually managed to get some extra money, though much less than he expected and needed, from some of the PCTs. As Robert Evans recalled, "It wasn't going to solve our problem, but symbolically it was also really important because actually it symbolized to say the Hospital B is getting its act together".

As for the relationship problem with the Strategic Health Authority, Robert Evans felt that, after the death of Jackson Cameron, his relationship with the Strategic Health Authority had deteriorated to the point of no return. For Robert Evans, the SHA had formed an extreme and inflexible position that the cause of the Hospital B's problem was solely inefficiency. The SHA's opinion, he believed, was echoing throughout the whole health system and had the potential effect of not only preventing the Trust from getting support from the external stakeholders, but also mounting the pressure over the Trust. So in order to get his message across that Hospital B was doing its homework but a definitive solution of the problem would only come with an involvement of the whole system, Robert Evans found that he had no option but to bypass the Strategic Health Authority. The way he found to do this was to use his own contacts within the Department of Health:

> "Because I knew people at the Department of Health, I went straight to them and said, 'There isn't just crap down here. You guys aren't listening to us'. I used the turn around team. I used KPMG who assessed us to feed back up the system to say, 'Those guys in the Hospital B are doing everything and more than we'd expect anywhere in the country, and actually the other part of the system needs to help here'. So I went above and around the system because I couldn't get any traction here."

Providing a 'long-term' strategic vision

Robert Evans realized that fostering a sense of 'crisis' and 'threat' was an effective way to get influential clinicians on board in the short-run, but might not be sufficient to sustain the clinicians engagement in the longer term. A permanent sense of

crisis and threat to engage people with the cost reduction efforts would not be healthy to the organisation. He strongly believed that it was also necessary to offer hope and an appealing vision of future to sustain a more long term and effective relationship with clinicians:

> "The way in which we tackled the cost improvement programme was always going to be short term. You can't do that year on year. It was brutal, unsubtle and tough, although the people did it and the results were fantastic. But at the same time you had to offer hope and the future. You can't always be in crisis. You have to start to paint the picture about what the organisation will feel and look like in 5 years time."

With the help of the director of strategy and planning, he launched an important initiative in order to provide a long-term strategic direction to the organisation, which was dubbed 'The Hospital B 2010'. Robert Evans wanted the formulation of the strategy to be carried out with the participation and involvement of the key stakeholders. Thus, the formulation of the strategy involved two big events where representatives of key internal and external stakeholders got together to discuss key strategic issues, and a series of internal meetings with staff. The big events were conducted in two rounds, with approximately 60 people including representative of staff, PCTs, GPs, SHAs and Patients. In the first round which took place in September 2004, they sought to identify and discuss key strategic issues concerning the Hospital B, such as the national and local context and trends affecting the health economy, the expected role for the Hospital B, as well as what would be its objective, values and big strategic issues.

The second round took place two months later, when the draft of the Trust's strategy was presented and discussed. The purpose of the second round was to secure collective support for the resulting strategy and, above all, crystallize the view among key stakeholders that, though the Trust was facing a 'crisis', it had a consistent long-term strategy. Between the two big events, the director of strategy and planning carried out a series of open meetings with staff to get their insights, particularly on the 'values' that would underlie the strategic direction of the Trust. Once the key stakeholders were happy with the resulting Strategy, it then was presented and got the approval of the Trust board.

The Hospital B 2010 thus provided a context within which the Trust formulated its annual plan. However, the practical benefit of the Hospital B 2010 in terms of serving as a 'live' guide that could be translated into the organisation's annual plan and cascaded down into the units' objectives was said to be much limited. The strong financial pressure imposed to the divisions, coupled with the need to hit the national targets, has meant that managers would have limited discretion to carry forward their local agendas in line with the Hospital B 2010 vision. As an executive director recalled:

> "Because money was everything and there's a whole list of national targets, by the time you get beyond that what discretion do you have to set the local agenda? And a lot of our effort has been about getting our house in order against the national must-do's rather than the local agenda."

Changes in management control processes

When Robert Evans entered office, he found that the organisation already had in place the basic information system and data that allowed a fair understanding and monitoring of performance concerning the key performance targets. This was due to a great extent to the efforts implemented by Paul Elton. He believed, nevertheless, that there still was room for improvements and decided to make some changes in the way performance information had been reported and reviewed. The first initiative was the introduction of the balanced scorecard system in the end of 2004. The system was not introduced at once. Quite the contrary, it took a long time and went through several iterations, as the organisation sought to perfect the system around the kind of information to be included and an adequate level of aggregation. As an executive director described it:

> "It's had iterations since [it was introduced]. Mainly about trying to distil it down into a few indicators and once we've distilled it down to a few indicators then there's a wave of recognition that doesn't give you the richness of the picture and therefore you need to start adding to it and then you strip it down again and start adding to it."

This process of continuous changes and adjustment in the information system, however, was felt at the lower levels of the organisation to be quite disruptive, with an adverse effect on the development of the managers' capabilities to control and monitor their unit's performance. When asked about how the performance information systems available for the units at a middle level of the organisation had changed over time, a manager commented:

> "There would have been something else I'd expect, and there might have been periods without anything.... So when I talk to some departments they've said, 'Oh yeah we used to get a really clear score card of our activity and performance, but we got a few of them and then it stops'. And then they might say, 'And then 3 years before that we had something and then it went for a little bit and then it stopped'. So again things... so it's not through lack of trying that things we haven't been there, but there isn't a set package of information against key targets which have been in place for a while."

As for the performance review processes, one of Robert Evans's early initiatives once in office was to establish three kinds of formal meetings to review and respond to the performance feedbacks. The first was the quarterly performance review. The second was the monthly management board, where each divisional director and their management team met with him and the executive directors to go through their particular performance report against the key targets. Finally, on a more 'management-by-exception' basis, the Director of Service Delivery met weekly with managers and lead clinicians of divisional units where performance was not going on track.

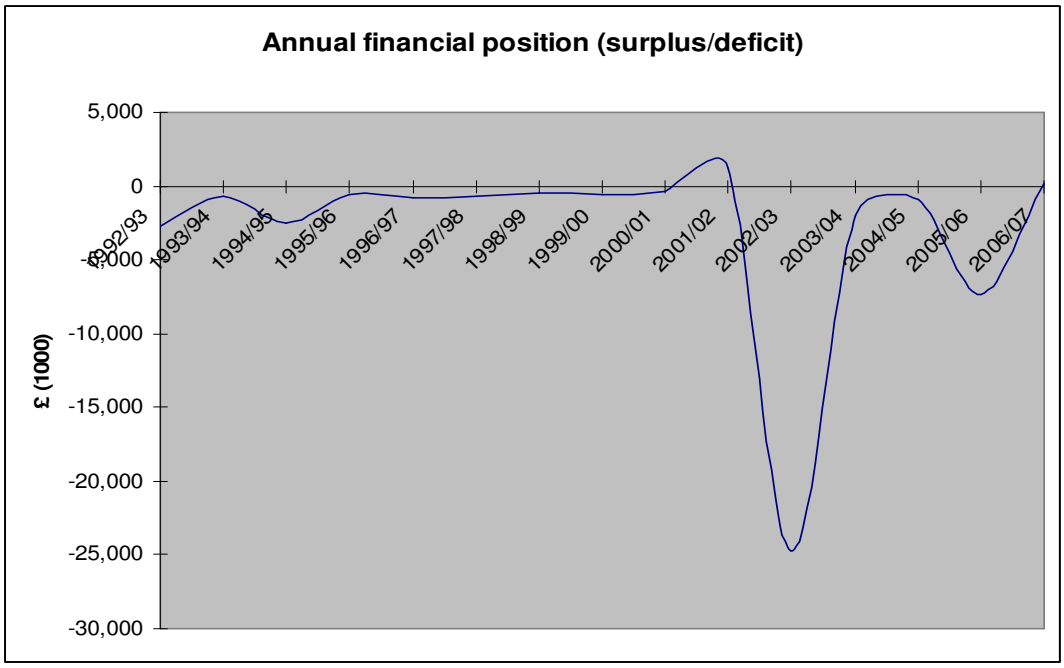
Results of Robert Evans's period

In April 2007 Robert Evans decided to leave the Trust to dedicate himself to his private consultancy work. His legacy was widely recognised by most of interviewees as having brought stability to the Trust and having solved the deep financial trouble within which the Trust was immersed.

Due to increasing external pressure and the huge financial deficit, which was viewed as threatening the own existence of the organisation, Robert Evans made a conscious choice to prioritize the achievement of financial balance, even if this would

come at the expenses of other performance targets. At the end of his three-year period, Robert Evans and his team managed to save the impressive amount of approximately £ 40 million. In the end of the 2006/07 financial year the Trust achieved, for the first time in its history[63], a financial balance, with a surplus of £ 0.14 m (see figure 6.6).

Figure 6.6. Hospital B Annual financial position



During his period the Trust showed a remarkable improvement in efficiency, as demonstrated by the Reference Cost Index produced by the Department of Health. According to this index, the Trust moved from a position of being 10 % less efficient than the national average (Index score = 110) in 2002/03 to 9% more efficient than the national average in 2006/07 (index score = 91).

As far as the Trust's overall score is concerned, in the first year of Robert Evans's period (2003/04) the performance of the Trust improved from two consecutives 'zero star' to 'one star". As he started with only five months left to finish the 2003/04 financial year, part of the upgrade in the Trust performance can also be attributed to the effort expended by his predecessor. Yet Robert Evans and his team were able to sustain the level of performance for two more consecutive years, despite the mounting financial pressure. Robert Evans knew that he would not achieve financial balance in the first two years and, thus, his idea was to achieve some savings and at the same time to do the best the team could do hit the targets. However, in the last year, considering the

[63] With the exception of 2001/02, when the Trust end the financial year with a surplus of £ 1.2 m. This however was only achieved due to a £ 17.9 m of external financial support received by the Trust.

prospect of £14 m in savings needed to achieve financial balance and turn the financial performance around, he took a conscious decision to deliver the financial balance, even if that meant that the Trust would lose on some performance targets. As a result, in 2006/07 financial year the Trust broke even, but got a 'weak' score in the performance targets, as shown in the 'Annual Health Check' (see table below). As an executive director recalled:

> "We made firm decisions, and when we saw our financial performance improving but not improving enough to get to zero, we identified that if we didn't open extra areas of the hospital to cope with pressures we could probably get to zero. And we made a decision, I remember making it, I was in that board, when the manager phoned the Executive on call at night to say, 'We've got a tremendous backlog of patients in A&E, can we open extra space and bring in expensive agency nurses to nurse it?' We said, 'No, you have to manage by finding more people to send home or you have to absorb that pressure in the A&E and we'll accept that we'll have some 4 hour breeches of the time, but we're not going to pay out more money.'"

Table 6.2 Performance ratings of Hospital B 2001-2007

Performance ratings								
2001	**2002**	**2003**	**2004**	**2005**	**2006**		**2007**	
					Quality of services	Use of resources	Quality of services	Use of resources
★	Zero star	Zero Star	★	★	Fair	Weak	Weak	Weak

6.4. John Thompson's period: *moving the organisation forward*

Re-engineering organisational processes: the Hospital B 2010 change programme

There was a general feeling among the executive team that the Trust was bruised by the immense cost-cutting sacrifice made to secure financial balance in the previous financial year (*i.e.* 2006/07). Due to the immense energy the executive directors had channelled into securing financial recovery, the achievement of the key performance targets took a back seat. The imperative of making cost-cutting savings was so high that the Trust could not make some expenses that were crucial to hitting the targets, such as filling consultant vacancies. It thus ended up being rated 'weak' for both 'quality of

services' and 'use of resources' in the previous 'Annual Health Check', representing the lowest level of achievement. However, despite the financial balance achieved, there was still the need to find recurrent savings to meet the long-term financial commitments which the Trust had from 2008/09, notably the £ 38 m loan[64].

In the short-run, the financial projections for the upcoming financial year showed a more comfortable scenario, in the sense that all necessary savings had already been found without the needed to impose an enormous financial sacrifice to the Trust. The executive team saw the relative absence of a financial pressure for the 2007/08 financial year as an opportunity to discuss and implement a more pro-active management approach, not only to anticipate to the needs of recurrently making savings in the upcoming years, but also to move the organisation forward in terms of the other performance targets. The executive team was convinced that the only way to address the performance target, without sliding back into the old financial deficit situation, was to improve the operational efficiency of the organisation. As an executive director explained:

> "We had two approaches we could take; we could either say, 'It's cost cutting' or, 'It's about service improvement.' And as of last year, i.e. as of 2006/07, we'd approached by just cutting budgets. And last year as an Executive team we accepted that you can't just keep doing that; you can't just keep salami slicing. That it was about looking at things differently; that it was about looking at our systems and seeing whether we could make them more efficient and we could get benefits out of them."

Thus, in the early 2007 the executive team, still under the leadership of Robert Evans, decided to launch a change programme, called 'Hospital B 2010 Change Programme'. The purpose of the programme was to streamline key organisational processes. Within the executive team, there had been several debates about what the focus of the programme should be. On the one side, the then finance director claimed that the programme should have a 'cost saving' orientation. On the other side, some of the other directors advocated a wider focus on process improvement, in which cost reduction turned out to be only one outcome among others, such as quality and patient satisfaction. As one executive director commented, "The benefits [of the programme]

[64] Hospital B, Press Release, Issue date 17 April 2007 'Hospital B 2010 Change Programme'

might be operational benefits so far as performance improves, or they might be benefits for patients. Or they might be benefits that allow you then to release some money".

Robert Evans accepted the idea of a more encompassing benefit for the programme, as opposed to a strict cost-saving benefit as advocated by the financial director. However, it soon became clear that the Trust was ill prepared to effectively implement this programme. Robert Evans then decided to go out to tender to contract out a consultancy company specialized in process re-engineering and re-designing. An executive director explained the reasons for outsourcing the programme as follows:

> "The reason we went out to consultancy was that internally we didn't think we had the capacity/capability to do it. And the second reason was actually to give a really strong message that it was important enough to do that we were willing to put our money where our mouth was, really."

In the run-up to the tender process, Robert Evans left the Trust in April 2007 and John Thompson an experienced manager with long-standing career in NHS hospital Trusts, took over as the new CEO of Hospital B as of June 2007. In the interim, the programme was then presented to John Thompson, who found himself in immediate agreement with the programme's idea and purpose. Even before officially taking up office, John Thompson got involved in and led the tender process. In April 2007, the tender process was concluded and the Trust's board agreed the appointment of the firm 'The Health Works', a consultancy company specialized in practice redesign and operational productivity of NHS hospitals, to deliver the programme.

The first milestone of the programme was called 'rapid discovery', which consisted in identifying project areas for improvement, i.e. potential areas where the benefits and the efficiencies could be found in the organisations. This first stage was concluded in May 2007, when 13 projects were identified encompassing both primary and support activities of the Trust's value chain. It was expected that the programme would improve the effectiveness and efficiency of these projects, including a £ 6 million cost reduction by March 2008, mainly through a combination of service redesign and/or re-engineering.

John Thompson's recent initiatives

Once formally in office, John Thompson carried the Hospital B 2010 Change Programme forward as a key element of his strategy to improve performance targets and achieve long-term sustainable financial balance. In parallel, he took three key initiatives to help the organisation to achieve these objectives: tightening up performance management; revamping governance structure; and introducing a sense of business-unit across the hospital specialties.

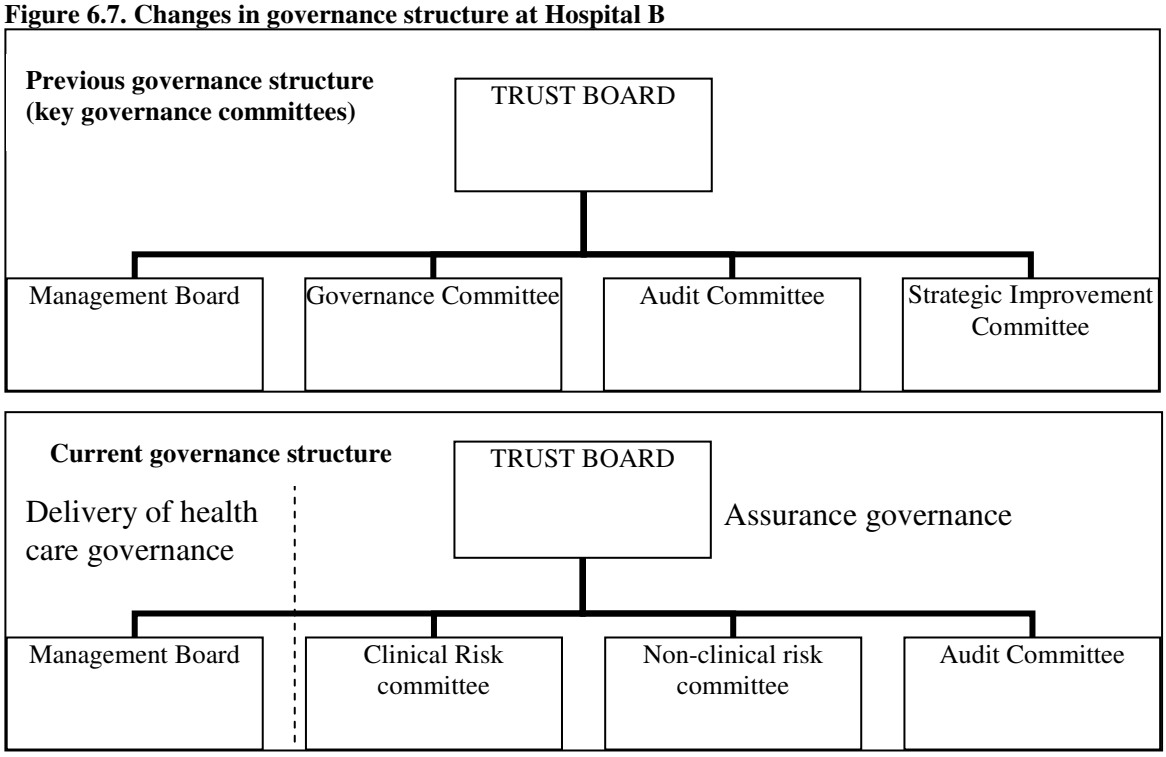
John Thompson has been described as a hands-on, transactional leader in terms of performance management. One of his early initiatives after entering office was to change the periodicity of the performance management review meetings with the divisions from quarterly to monthly, or even weekly when it was the case that the performance of the division was below the expected level. As he put it:

> "When the performance of the surgical division was right off plan, I stepped up the performance meetings and met then weekly. I used to say to them, 'As soon as you start to perform I am happy to meet you on a monthly basis'. We had weekly meetings for approximately three months, then, when the performance improved we returned to meet monthly."

Regarding the governance structure, John Thompson found that there was no clarity between the delivery and assurance governance processes in the Trust. The former involves the issues related to the performance of the Trust, whilst the latter refers to the assurance the Trust needed to have about the arrangements in place to mitigate the clinical and non-clinical risks of the Trust's operations. Thus, in November 2007 he changed the governance structure of the Trust by separating and making clear the governance structure for the delivery of healthcare and the assurance process. The latter was also revamped by separating Clinical Risk governance from Non-clinical Risks governance. Previously, these two aspects were under the same umbrella of the Governance Committee. There was a shared view, however, that, when under the same committee, the Non-clinical Risks was often under Clinical Risks' shadow and therefore did not always receive a full attention. The purpose of this change was thus to ensure that both delivery and assurance, for both clinical and non-clinical risks, had been

properly and thoroughly discussed prior to the presentation of the Board. A simplified representation of the changes in governance structure is displayed in the figure 6.7.

Figure 6.7. Changes in governance structure at Hospital B



Finally, John Thompson wanted to instil a more business-oriented culture into the specialties across the organisation. The idea was to change the way lead clinicians perceive and approach the financial aspect of their units, from the traditional 'income & expenditure' perspective to a sense of 'loss' or 'profit' in the units. He initially set up three pilots, representing three specialty units in the Trust, and two other units joined at a later stage. John Thompson's explained the rationale of this initiative as follows:

> "Clearly one of the reasons we're doing that is because consultant, doctors and everybody in this place are incredibly competitive. And we say, 'xxx Specialty is making this much of a profit but you're actually generating a loss to the hospital.' Their natural reaction apart from saying, 'The data's rubbish,' which is always the first thing, is for them to say, 'Ok what is it that I can do to turn myself to my department and generate profit-making bit of this organisation as opposed to a loss-making bit of this organisation?' And we've seen evidence of that already. People sitting down working through their processes thinking, 'How can I take some steps? How can I be slicker? How can I reduce costs?' throughout that process."

Overall, the initiatives taken during this period, in particular the Hospital B 2010 Change Programme and the tightened performance management approach have produced satisfactory results in terms of performance against cost reduction and the key performance targets. By the time this case study was written, there was a general air of expectancy regarding the publication of the next 'Annual Health Check' ratings, when the Trust is expected to receive a score of at least 'Fair', for both 'use of resources' and 'quality of services'. As John Thompson put it:

> "Quite frankly this year our view is that we will be "fair, fair". Were it not for the loan we'd be "good" on money (use of resources). And were it not for two or three targets we'd be "good" on quality and services. So we've really made huge changes and for 2009 our ambition is at least to be "good, good" on these ratings, and I'm very confident that we'll get that because we've got that grip and focus on these targets."

6.5 - Summary

This chapter presented a case of a trust went through a less successful and more turbulent recovery and renewal process. There were three different stages representing different attempts to recover the organisation, each triggered by change in CEOs. The first two attempts failed, but the third one eased the Trust into a recovery strategy. The financial recovery was eventually achieved in the 2006/07 financial year, when the Trust genuinely broke even for the first time due to an enormous cost-cutting exercise. In terms of the performance targets, the results showed that its overall performance had not yet reached a consistent satisfactory level over the period since the national ratings were introduced, although there had been some spells of improvement. However, recent evidence projects a more positive result for the 2007/08 year 'annual health check', suggesting that the Trust has now possibly embarked upon a promising upturn trajectory. Therefore, this is not a case of being one of the 'permanently failing organisations,'[65] but of an organisation that, having been perceived as being a 'failing organisation', took longer than the Hospital A case study organisation to get into a sustainable recovery trajectory.

[65] See Meyer and Zucker (1989) *Permanently Failing Organization*. London, Sage.

Chapter 7 – Explaining the recovery and renewal process – A cross-case comparison of HOSPITAL A and Hospital B

7.1 – Introduction

The previous chapters presented two episodes of recovery and renewal of two hospital trusts in England. In both cases the initial condition was one of 'failing', according to the then established, 'star rating' system. The HOSPITAL A was the only Acute Trust in England to receive a 'zero star' for three years in a row since the first publication of the ratings in 2001. Similarly, the Hospital B received 'one star' in 2001, followed by two consecutive 'zero star' scores in the ratings published in 2002 and 2003. In both cases the recovery and renewal attempts were triggered by changes in CEOs combined with external pressure.

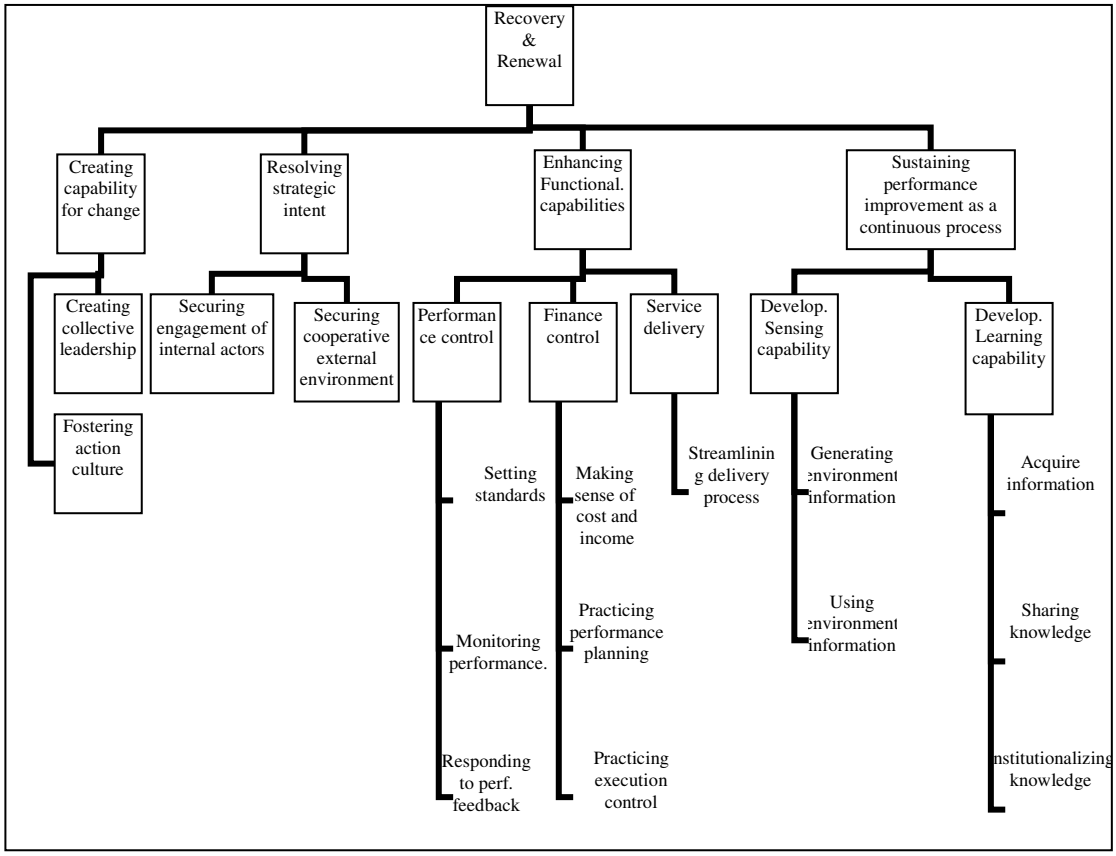
There were striking differences in the trajectory and outcomes of the recovery and renewal process of the two cases. On the one hand, HOSPITAL A went through a continuous upturn trajectory, locked into early attempts to recover and renew. The outcome of the episode was the score of 'Excellent' for 'Quality of Service' received in the last Annual Health Check, along with a sustainable, positive financial situation. On the other hand, Hospital B went through three different stages representing different attempts to recover the organisation, each triggered by change in CEOs. The first two attempts failed, but the third one eased the Trust into recovery trajectory. The outcome of the Hospital B trajectory was a financial balance, but with a 'failing' score on the last result of the Annual Health Check. Therefore, the question arises as to what explains the differences in trajectory and outcome of the recovery and renewal attempts of the two cases. By addressing this question, we aim not only to shed light on the causal factors that explain recovery and renewal in public service organisations, but also to provide useful advice on how managers of public service organisations can achieve valuable results as an outcome of the recovery and renewal process.

The way we chose to address this question follows two major stages. Firstly, we dissect the recovery and renewal process into its component processes. Each component represents a different challenge that needs to be satisfied with some success if the organisation is to recover its performance and sustain good performance in the long-run.

Secondly, we identify the causal factors that explain the outcome of the efforts to satisfy each of the challenges.

The key component processes of the recovery and renewal process drawn from the cases studies are depicted in the framework presented in figure 7.1. The component processes are laid out in a hierarchical form, i.e. decomposed into lower order sub-steps, each of the latter being in turn a 'parent' of the next lower level.

Figure 7.1 – Decomposing recovery and renewal process



The purpose of decomposing the recovery and renewal process into its hierarchical component steps is to reduce the complexity of the analysis of the causal factors that explain recovery and renewal. Herbert Simon, in his seminal book *The Sciences of the Artificial* (1996), highlights the fact that decomposability is a property of most complex social systems. He goes on to argue that "the fact then that many complex systems have a nearly decomposable, hierarchic structure is a major facilitating factor enabling us to understand, describe and even "see" such systems and their parts" (p. 207). Indeed, it is easier, and perhaps more accurate, to reason about the causal factors that explain the outcome of the specific steps of a complex process, taken separately, than of the process as a whole. In the case of the organisations presented in

this thesis, for instance, one could ask how a given characteristic of the context of the organisation contributed to satisfy (or precluded the satisfaction of) any of the four major challenges involved in the recovery and renewal process.[66]

Having dissected the recovery and renewal process into its component processes, or challenges, we now turn to explain the second stage of the analysis of the cases, which is to identify the causal factors that explain the outcome of the key processes. Consistent with processual analysis (Pettigrew, 1997), we identify two groups of causal factors: process design features and context factors. The former is defined as 'an array of elements that are crafted by the organisation to make the operation' of the relevant process workable (Barzelay and Campbell, 2003). It is, therefore, the element of managerial intervention and action. The latter includes the characteristics of inner and outer context that influence the outcome of the component process under analysis (Pettigrew, 1987).

Therefore, our empirical analysis of the two cases is geared towards answering the following question: how do the managerial intervention (process design feature) and the contextual factors explain the different performance characteristics of the two cases, considering the challenges involved in the recovery and renewal process? This chapter then proceeds by detailing how the combination of process design features that were crafted by the managers and context factors of the two cases contributed (or not) to satisfy each of the above mentioned challenges.

7.2 – Creating capability for reacting and changing

Studies on organisational renewal and change have highlighted the importance of creating a management team committed to renewal and change (Baden-Fuller and Stopford, 1996; Pettigrew *et al*, 1992; Pettigrew and Whipp, 1991; Grinyer *et al*, 1988). Recovery and renewal of the performance of a 'failing' organisation is rarely achieved by a one-shot fixing-up of a single great issue that is seen to be dysfunctional. It rather involves changes in the different aspects, parts and levels of the organisation (Baden-Fuller and Stopford, 1996). Thus it is difficult for such multi-faceted changes to be brought about by acts of a single, 'heroic' leader. Empirical studies on management of

[66] A similar framework has been fruitfully used by Barzelay and his colleagues to analyse other organisational processes, notably strategic planning (Barzelay and Campbell, 2005), cost control (Barzelay and Thompson, 2003) and public programs implementation (Barzelay and Shvets, 2006).

change led by Pettigrew in both public and private organisations (Pettigrew and Whipp, 1991; and Pettigrew *et al,* 1992), demonstrated that leading changes requires a 'collective leadership' if the changes are to have effective, long-term results. This collective leadership, they maintain, involves the formation of a managerial cadre made up of managers and key lead professionals at both executive and operational level who are convinced of, and committed to, the need for change.

Building capability for change thus concerns creating and sustaining teams of managers, at both executive and more operational level, committed to changes and ready to act in response to adverse performance feedback. This helps to build the momentum for change which is necessary to overcome the forces for continuity (Leavy and McKiernan, 2009). The operation of this function was found to be a crucial difference between the HOSPITAL A and Hospital B cases.

In the HOSPITAL A this functional requirement was largely satisfied by two major undertakings, namely: creating a collective leadership by making key people available in critical posts across the Trust, at both executive and operational level; and fostering of an action-oriented attitude among managers within the Trust. The formation of the collective leadership started at the top management level, with the arrival of Martin Mueller as the new CEO and the subsequent appointments of Peter Dawn as the Chief Operating Officer (COO) of the Trust and Jonathan Sheffield as Medical Director.

As described in the narrative, the COO post, as opposed to the traditional post of Director of Operations, was deliberately created to have, at the top management level, an executive with a clear mandate and authority to bring about change in the organisation. The appointment of Peter Dawn as the Trust's first COO was also a key step in the introduction of change agenda in the Trust. Peter Dawn was described as an active leader with a demonstrated 'bias towards action'. Being a medical graduate with a high-level management education and experience, he was able to understand the concerns and communicate easily with both clinicians and managers.

The leadership at the top management level was reinforced with the appointment of a medical director committed full-time to the executive position and with a demonstrated leadership capacity. At a more operational level, this functional requirement was satisfied by the selection and appointment of the 'head of divisions',

under the general principle that those selected should necessarily be clinicians with demonstrated leadership capacity and commitment to the managerial agenda. Peter Dawn described the selection of clinicians to lead the recently created clinical divisions as an opportunity to choose the '*best levers'* for each division.

The other process design feature that contributed to creating the capability for change was the action-oriented culture fostered by Peter Dawn. Peter Dawn systematically disseminated the notion across the management team that "a variance explained is not a variance managed". The purpose was to foster a culture in the organisation by which managers would be prompted to act upon adverse performance data, as opposed to expending energy and time finding excuses or blaming external agents for poor performance. As Peter Dawn recalled, "I switched the emphasis of the performance reviews meeting from 80 % on explanation and 20 % on action to 20 % on explanation and 80 % on action".

As important as the dissemination of the message about the need to focus on 'action' to foster an action-oriented culture was also the "sense of urgency" on the key targets deliberately heightened by Peter Dawn. This sense of urgency was generated by means of regular checking of what was done from a previous week to the next. The review meetings always ended with a list of actions and short term targets which would be assessed in the following week's meetings. A sense of urgency is thus part of the 'productive management of anxiety', which has the effect to increase the impetus for change in the organisation (Leavy and McKiernan, 2009). These process design features, combined with the selection of clinical leaders who were more likely to 'act' on than to 'explain' poor performance, helped to create within the HOSPITAL A a collective leadership committed to change.

Two contextual factors contributed to the creation of a collective leadership committed to change, namely a balanced external pressure and relative management stability. Martin Mueller entered office when the central government had already given up its policy of franchising the Trust. Martin Mueller thus could enjoy a less intrusive external context. Furthermore, during the whole period of analysis there was a relative stability and continuity of the management team. Paradoxically, the substantial degree of stability was crucial for Martin Mueller to be able to create a strong executive team committed to the changes.

By contrast, in Hospital B this challenge (creating capability for change) was not successful during the first two stages of the turnaround attempts, notably during Mark Norton's and Paul Elton's term of office. During Mark Nortons's period the managerial turmoil caused by the investigations of the waiting-lists and questionable accountancy practices, and abuse of private practice, prevented him from assembling a strong management team committed to change. Quite the contrary; during his period he witnessed a rapid turnover of most of the key executive directors. During Paul Elton's term there was the first attempt at galvanizing the management team, notably with the establishment of the 'do or die' meetings, which injected a sense of urgency among some key senior managers. Nevertheless, this process design feature was not on its own sufficient to create a collective leadership across the organisation. During his period, the Trust was hit by the intense pressure from the central government to franchise the Trust. The external pressure had the effect of engendering a sense of impermanence among the management team. Due to the clashes with the national policy he, with most of the executive team, left the Trust.

It was not until Robert Evans' arrival that the Trust could enjoy a period of relative managerial stability and absence of highly intrusive policies from central government. He started assembling what turned out to be a much more stable and stronger executive team. Like Martin Mueller, he also arrived at Hospital B after the decline of the franchising policy and could also enjoy a less intrusive external pressure, following an orchestrated process of change in leadership in the southwest region implemented by Jackson Cameron. However, unlike Martin Mueller, Robert Evans could not count on a change in the organisation's structure as an opportunity to select the 'best levers' for key operational positions. The organisational structure had recently been changed by his predecessor and for Robert Evans another change in a short period of time could be traumatic. Hence, apart from the selection of key people within the executive level and the finance department, few other changes were implemented in the other functions at a more operational level, especially among lead clinicians. The formation of a 'collective leadership' during Robert Evans's period was thus more selective than it was the case for HOSPITAL A .

The effectiveness in performing the function of creating capabilities for change was a crucial difference between the Hospital A and Hospital B cases. This supports the argument that creating a capability for changing is a crucial step in the renewal and

recovery process (Baden-Fuller and Stopford, 1996). This function involved creating a 'collective leadership', characterized by the existence of key people committed to and leading change at different levels and parts of the organisation (Pettigrew and Whipp, 1991; Pettigrew *et at,* 1982). Our inductive analysis revealed that such functional requirements can be effectively satisfied by such management practices as conscious team-building (using a formal selection process to put key 'levers' in the key positions); increasing the 'capacity for action' by heightening a "sense of urgency" and setting expectation among managers that an action-oriented attitude should prevail when faced with adverse performance feedback (more emphasis on 'action', as opposed to 'justification').

It also demonstrated that the outcome of an attempt to galvanize the management team is more effective within a context of managerial stability. The differences in managerial stability between the Hospital B and Hospital A cases are clearly evidenced in the figure below.

Figure 7.2. Changes in CEOs and Financial Directors in Hospital B

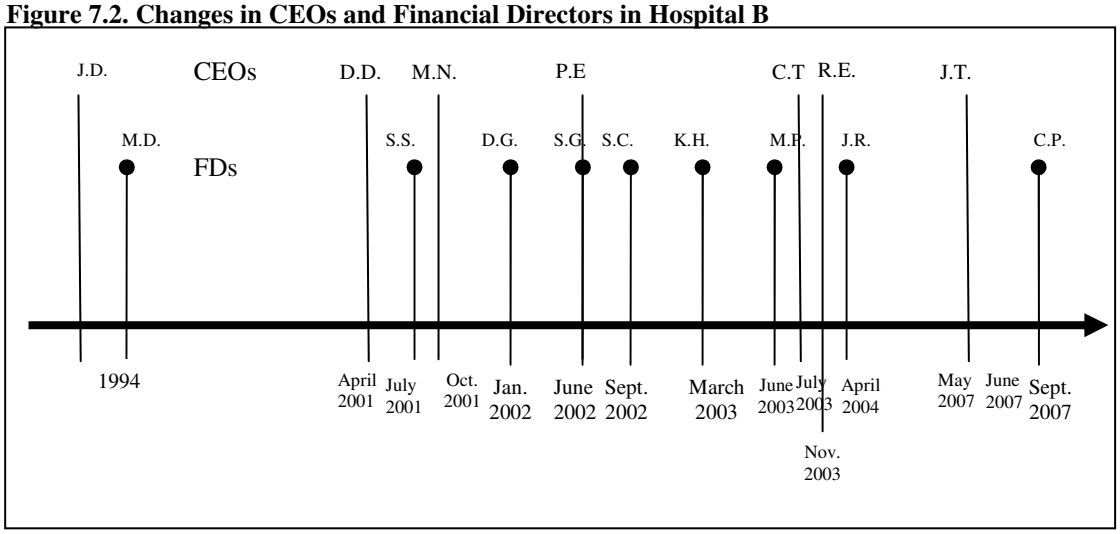
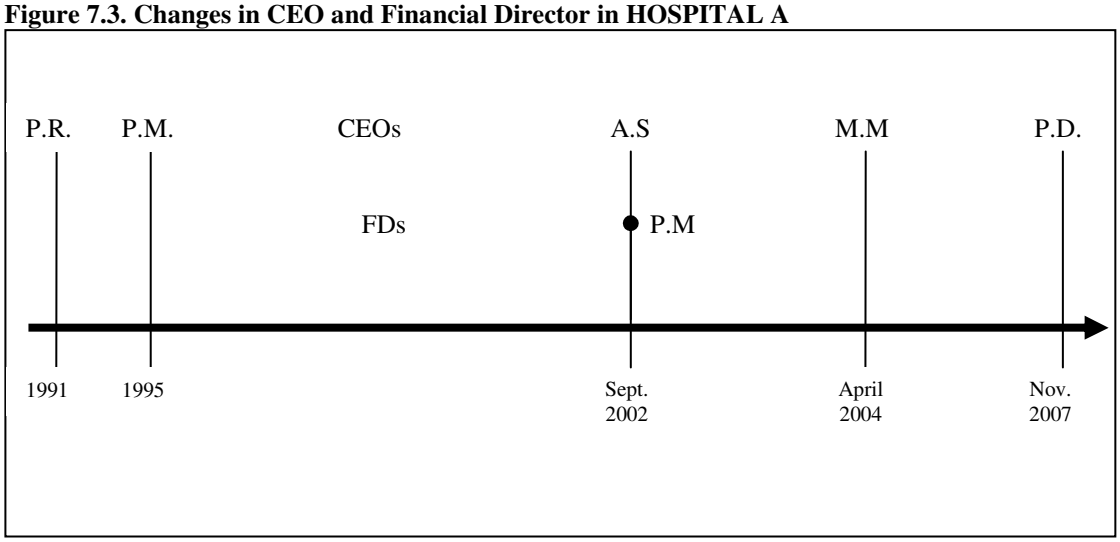


Figure 7.3. Changes in CEO and Financial Director in HOSPITAL A



7.3 -. Resolving strategic intent

7.3.1 Securing internal engagement

Securing engagement of internal actors is advantageous for accomplishing the recovery and renewal a 'failing' organisation. This is mainly because recovering and renewing an organisation involves changing some established values, processes, behaviours, priorities and/or structure of the organisation. These changes often alter the power relations within the organisation, resulting in an opposition or resistance of the groups affected by the changes. Meyer and Zucker (1989) argue that the failure of an organisation to implement the changes deemed necessary to recover and renew the organisation is due to a 'stalemate' between those actors who want to change the organisation and those who need the organisation in its current template. Hardy's (1990) research in both public and private organisations found that failure to implement retrenchment strategies can be attributed, among other causes, to an orchestrated opposition campaign conducted by powerful interest group. Similarly, Jas and Skelcher's (2005) research shown that divergence in interest between key actors was an important factor that explained failure of local authorities in England to turn their performance around.

In professional organisations, as it is the case of the two organisations under analysis, the need to secure engagement from key internal actors, qua professionals, gains especial relevance. This is because in this kind of organisation, professionals (such as doctors) have considerable influence and power in relation to the production or delivery of services (c.f. Mintzberg, 1983). Empirical studies on failure and recovery of hospital trusts in England have shown that the lack of engagement of clinicians with the managerial agenda was a determinant factor of failure (Protopsaltis *et al* 2002; Fulop *et al*, 2004).

In HOSPITAL A the challenge of securing the engagement of powerful clinicians was largely satisfied by a conjunction of process design features and context factors. One process design feature was the communication pattern between the key executives, notably Peter Dawn and the medical director, Jonathan Sheffield, and key clinicians. Peter Dawn gave a strong emphasis to the importance of establishing an open communicating channel with key clinicians. He was constantly communicating with key

clinicians, in both informal and formal events, such as the doctor's away day. This open, continuous communication pattern was important to secure engagement for two main reasons. On the one hand, it served as an opportunity for Peter Dawn to identify, face and offset the argument of 'negative' leaders. On the other hand, it germinated an overall sensation among clinicians that their concerns had been listened to and were given proper attention by executive managers in the organisation. When asked about the key factor that led to clinicians engagement in HOSPITAL A an influential doctor responded:

> "It was just constantly reiterating that clinicians are important and listening to what they have to say; not always doing what they want, nevertheless always being seen to be listening. I do feel that the appointment of the COO was very, very important because that person was literally listening to the issues and reacting to them"

A second feature was to have influential clinicians who were committed to the change agenda in key leadership position within the Trust. The executives most involved with the operations of the Trust, therefore who interact with professionals on a daily basis, had at the same time a clinical educational background and a demonstrated leadership capacity. These positions were the Chief Operation Office, the Medical Director and the Head of Divisions. The COO, Peter Dawn, was a medical graduate with strong managerial knowledge and experience. The Medical Director was selected because of his demonstrated leadership capacity. Similarly, the head of divisions went through a normal selection process, in which being a clinicians was a necessary condition, but not sufficient. It was also required that they had a demonstrated leadership capacity and a commitment to the managerial agenda.

Having the linking, managerial positions filled by clinicians committed to the managerial agenda had the effect of legitimizing the managerial actions among the clinicians community. Professionals display more propensities to engage into managerial actions if they perceive them as legitimate (c.f. Suchman, 1985; Zott and Huy, 2007). Clinicians are more likely to perceive an organisational directive as legitimate if it is proposed by a reputable clinician, rather than from a non-clinical manager. The reason for this is twofold: firstly, clinicians in managerial position are more capable of providing plausible arguments and explanation for the desired changes.

Secondly, the clinician community assumes that a clinician in a managerial position, as opposed to a non-clinician manager, is more capable of understanding challenges and embed their medical profession values into the decision-making. These two reasons are consistent with what Suchman (1985) called legitimacy based on "comprehensiveness" and "taken-for-grantedness". Pettigrew *et al* (1992) found that implementing change in a public hospital was easier where managers had a hybrid background.

As an executive director of HOSPITAL A observed:

> "Having clinicians as head of divisions was the primary kick start for it[clinical engagement], yes. People saw that as a symbol of where we were going and realized that ok, if they mean it, if they're that serious about it, then you know, other clinicians feel that yeah their views are going to be taken account of, and so it's been easier to then get other clinicians engaged in other management."

A third process design feature to bring about clinicians engagement into the managerial agenda was to involve the clinicians into the Trust's main decisional forums. The involvement of clinicians into the decision making was increased by means of the creation of two decisional boards, namely the Trust Executive Group and the Divisional Boards. The TEG was composed of the six executive directors, the CEO and the five Head of Divisions. Thus, the way the membership of the Trust Executive Board was composed afforded a stronger decision power to clinicians than non-clinical executives. Two out of the six executive directors were clinicians (the medical director and the director of nursing) and all head of divisions were clinicians. Hence, the majority of the Trust Executive Group were clinicians. Similarly, though at a more operational level, the Divisional Boards pulled together the managers and the lead clinicians of all clinical specialties, to make decision regarding the operational and strategic issues of each division. As Martin Mueller put it:

> " what it did in terms of the clinical involvement was changing the executive team dynamic so that it was clinically qualified, because immediately you've got the potential for me, the Finance Director, the Strategy Director, the HR Director to be out voted... not that we have votes, but you know, in balance by the 5 Clinical Heads of Divisions plus the Medical Directorate, the Nursing

Directorate, so we suddenly changed the management team so that it was a clinically focused management team"

The involvement of clinicians into the decision making process, at both executive and more operational level has the effect of stimulating an effective managerial-clinical relationship (Shortell *et al*, 1990). An effective managerial-clinician relationship, in its turn, has shown to be instrumental in bringing about strategic change in an organisation. Pettigrew *et al*'s (1992) research on the NHS organisations found that the quality of the managerial-clinical relations was an important determinant of a favorable context for change.

A fourth process design feature was the educational programme organized by the Trust and Keele University to give management and leadership training to all managers, head of divisions and lead clinicians. Such an educational programme had the intrinsic effect of not only providing management knowledge to managers and clinicians, but also helped to create a common language between them. Clinicians, in general, do not receive management education as part of their educational curriculum. Thus, the provision of management education to lead clinicians reduces the cognitive barrier, enabling them to 'think across the patch'.

In Hospital B the engagement of clinicians with managerial agenda followed different patterns. During Paul Elton's period, an important process design feature that contributed to engaging clinicians into the managerial agenda was the establishment of the Boards to lead the two recently created divisions. The Boards put together lead clinicians and top managers to discuss and make decision about the key operational issues.

However, the long, intense period of managerial instability, a contextual factor, made the clinicians' engagement more volatile and difficult to sustain in Hospital B than was the case in HOSPITAL A. An interviewee illustrated the effect of the managerial instability on the engagement of clinicians at Hospital B as follows:

"A very senior person [clinician] in the organisation turned around to one of the general managers and said "well why should I do that?". He [manager] was saying, "this is how we can make something better" and he [clinician] actually said, "well why should I do that because next week you might be gone?" and if

you think back to the rate at which Hospital B at one point turned over its Chief Executives, turned over is Finance Directors, turned over its Executive team, why would you as a clinician invest in an Executive team if actually you didn't see them continuing into the future?"

Another interviewee added:

"In this period from 2001 to when Robert Evans came the clinicians, the bulk of them, were very, very cynical. Very, very cynical of management and would say "oh well I'll be here next week but you won't" that kind of stance."

And again:

"When we went through this period of instability, whilst I think the people like Gabriel Dodgson and Mark Norton, and Paul Elton, all of them generally wanted clinical engagement because they saw it as the only way to really get moving. It was very difficult to affect clinical engagement. I mean if you asked a Director and said look at its finances and make savings, if the Finance Director is lasting on average two months, it's really difficult to engage with that. So the instability in the Executive team made clinical engagement very difficult for that period."

Robert Evans' period was marked by the implementation of retrenchment strategy, considering the enormous accumulated financial deficit and the need to bring about financial recovery. Securing financial balance was potentially difficult because it required an immense sacrifice from the part of clinicians. The challenge of engaging key clinicians into the "saving" agenda was exacerbated by the effect of the aforementioned instability of the management team. Why was the Trust able to secure the level of clinician's engagement necessary to meet the huge saving targets imposed by managers? Several process design features and a context factor played a role. As this episode was presented in detail in the narrative, we discuss the process design features and context factor only briefly.

The first process design feature was an intense and open communication between, on the one hand, the financial director and the CEO and, on the other hand, the lead clinicians. Both the CEO and the Finance Director were described as having

established an open and trusting communication with clinicians. A second, and related, process design feature was the 'attribution of threat'. Robert Evans furnished his argument to justify the need for savings with the recurrent idea, which floated in the external environment, that reducing the scope of Hospital B was a plausible solution for its financial problems. Thus, Robert Evans sent the message across that if clinicians did not engage in the managerial agenda, Hospital B ran the risk of ceasing to exist in its current form. In doing so, Robert Evans activated a social mechanism known in the sociology literature as "Attribution of threat" (*c.f.* McAdam *et al*, 2001). This social mechanism has the effect of bringing about engagement because, when activated, actors believe that important values (*e.g*. the Hospital B in its current form) will not hold in the future, unless they engage with the proposed changes. A third process design feature was education. Similar to the case of the HOSPITAL A, a leadership development programme was also implemented to provide management training to lead clinicians and managers.

The effect of the process design features was enhanced by a context factor, namely: an existing belief among some stakeholders that Hospital B, in its existing form, was over dimensioned in relation to the characteristics of its external environment. According to this view, any sustainable solution to Hospital B would necessary have to consider the reduction of the scope of the Trust in terms of the different type of specialized services provided. Robert Evans could then use this generalized perception to justify the need for clinicians to engage in the cost-cutting policy. An external stakeholder expressed his vision of the Hospital B's problem as follows:

> "Hospital B had a number of high profile clinicians who have been allowed to set up specialist clinics, specialist operating, specialist therapies if you like that are basically duplicating the territory role of Hospital A, which is only half an hour away… the fundamental issue in Hospital B is you've got the wrong set of doctors for the population…There are some fundamentals that need to change to move Hospital B on, and one is it needs to become a District General Hospital for its population, and it needs to stop the high cost specialist interventions that it currently does. [Becoming a district general hospital] means it doesn't need to be a specialist hospital; it has some specialism in its clinical disciplines, in its clinical treatments but it doesn't need to do, because that can be done in Hospital

A. And that's a high cost…Hospital B has a capacity issue because it's trying to do something that it's not built for."

7.3.2 – Securing cooperative external environment

Securing a cooperative external environment is effectively performed when the organisation creates an externally supported, shared interpretation on how the organisation should change. In HOSPITAL A this requirement was satisfied by Martin Mueller's emphasis on establishing closer relationship with key external stakeholders. Key initiatives in this direction were the frequent meetings with CEOs of external stakeholders and local organisations, and the executive-team-to-executive-team meetings with other hospitals trusts. Another process feature was the creation of the position of Chief Operating Office. By delegating as far as possible the daily operational agenda to someone with authority to bring about change in the Trust, Martin Mueller could play a more external role, without being continuously dragged into minor operational issues. The availability of a Chairman with a strong link with the business community helped the organisation to secure a cooperative external environment.

In Hospital B, the challenge of securing a cooperative relationship with key external stakeholders was less successfully performed during the two main rounds of recovery attempts, notably the Paul Elton's and Robert Evans' terms. A process design feature and a context factor played a role in explaining the failure to secure a cooperative relationship with key external stakeholders during Paul Elton's term. A process design feature was the confrontational style he adopted in his relation with the commissioners. During his period, he went into a row with the commissioners over the financing of the Hospital B's deficit. This contention over the 'ownership' of the Hospital B's deficit prevented him from building a more effective relationship with the external stakeholders. As an interviewee recalled: "So relationships within the health community became very poor during his time and the PCT's were not really speaking to us, nor was the Health Authority."

A contextual factor was the management instability. The rapid turnover over his and his predecessors' periods made it difficult for the external stakeholders to establish a more effective relationship with the management team of the Hospital B. Earlier report released by Commission of Healthcare Improvement had already indicated the

difficulty faced by external stakeholders to establish a working relationship due to the frequent turnover of managers.

In Robert Evans' term, the quality of relationship with key external stakeholders was also not very effective. Similarly in Paul Elton period, the main source of tension came from the commissioners and the Strategic Health Authority. Both Robert Evans and Paul Elton tried to involve the health economy in sorting out Hospital B's problem. Though Robert Evans adopted a much less confrontational style, he did not manage to secure a supportive environment with commissioners. As he put it: "whichever way I did … I find that [relationship with commissioners] really difficult to handle, they were not supportive and I couldn't find ways to get them supporting." Regarding the Strategic Health Authority, after the death of Jackson Cameron, Robert Evans lost the support he enjoyed during the first months of this term. His relationship with Jackson Cameron's successor was described as appalling.

The unsupportive external environment was thus a context factor that explains the Trust's failure to obtain resources that could have help it to resolve its economic situation. As a consequence, the Trust had to go through an enormous saving sacrifice, which had an impact on the achievement of the other targets. As Robert Evans put it: "what I would've expected was some more help and support from the PCT's than there was. So, the cavalry never came over the horizon, but we also managed to balance the books. It was through our own work… we never got any external help."

7.4 - Building up functional capabilities

7.4.1 – Performance control

The managers' ability to control the performance of the organisation was obviously critical to the recovery and renewal. The link between performance control and performance resides in the potential of the former to regulate crucial activities in the organisaiton and 'by implication, output' (*c.f.* Mills, 1983). Such a regulation seeks to engage actors in corrective actions, as a specific response to a past experience of success or failure (*c.f.* Greeve, 2003). This kind of control is often called in the literature "cybernetic" (Antony, 1964) or "diagnostic" control (Simons, 1995). The importance of performance control in bringing about performance improvement has been well

documented in most empirical studies on both the failure and recovery of public and private organisations (*e.g.* Jas and Skelcher, 2005; Grynier *et al*, 1988; Andrews *et al*, 2006, Wilson *et al*, 1999). Moore (1995) found out that the emphasis on setting targets and performance accountability is relevant to recovery because it sends an implicit message across that performance matters and gives employees a focus on where concentrate its energy and efforts. As he put it: "the attention of the organizations shifts from worries and speculations about new bosses to the specific tasks that the new bosses have handed out" (p. 279)

A useful way to operationalise the performance control capability is by referring to the processes by which it is put into use. In the specific literature on performance control, such cybernetic or diagnostic control is often described as involving the following processes: setting standards and/or targets regarding critical performance variables; monitoring performance and; responding to performance feedback (Green and Welsh, 1988; Simons, 1995). The effectiveness with which the organisation operates each of these processes has shown to be crucial for explaining the different outcome characteristics of the HOSPITAL A and Hospital B.

In both HOSPITAL A and Hospital B the identification and setting of key performance targets was largely facilitated by a context factor, namely the well established performance assessment framework set up by the central government to evaluate the performance of the acute hospital trusts. The key targets and performance indicators created by the central government provided a clear notion of the performance standard that needed to be achieved by the hospital trusts in England. Once the rules and criteria for assessing the performance of the hospitals had been defined, the tasks left to the hospitals were: to fully understand how their performance will be assessed; to monitor the performance of the organisation against the key performance variables; and to respond to performance feedback.

In the HOSPITAL A there was a strong focus on understanding how its performance would come to be measured and assessed. As Peter Dawn recalled, "so one thing we introduced was a better understanding of each target, so if we were failing on a target we got to be experts on the definition or what was collected when, and we started to produce that information and feed it back to people, and teach people about the understanding of the target."

The monitoring of the performance against the key performance targets was effectively operated through two process design features: the creation of an information system (the 'target tracker'), which emulated the Healthcare Commission's performance assessment framework; and more frequent, systematic review meetings with all concerned actors. The target tracker provided coloured information on how well the Trust was performing against the key targets and performance indicators. Such process design features enabled the Trust to have the right information available for the right people at the right time and in a simple and understandable format. With the information from the 'target tracker', Peter Dawn's team made sure that all relevant people received the information, both during the weekly review meetings and by pinning it on the doors of the key managers. As a director commented:

> "we needed to have failsafe, so we have information that says red flag, "somebody's waiting too long. So an alert comes up, and helps manage the process…over time we developed much more focused information and much more routine information, and much more frequent. And we started to produce reports which actually put red, amber or green on patient waiting times or whatever the target was so that it was an instant alert about the problem… So I think that management control comes through having the right information and then through using the information. That was the biggest aid to more control".

Another director remarked:

> "[the report of the target tracker] is highly visible, everybody talks about it and we use the same format in the management meetings, so people are now familiar with what the target tracker is, what it says and how to read it."

Responding to performance feedback was successfully accomplished by an increased performance accountability introduced by Martin Mueller and Peter Dawn. It was a strict requirement that all review meetings ended up with a list of corrective actions alongside the name of the persons responsible for implementing them. In the following meeting, all of them were called to account for their designated action. Peter Dawn illustrated this approach as follows:

"Two examples of that is the 4 hour wait in A&E, and the cancer targets and both of those we've used a system of regular meetings with an action plan which is updated and checked every time we meet….so I as Chair would say "you know, why do we think there's a problem with flow of patients through this pathway?" and people would discuss it, we'd look at some of the data and we'd agree that something was a problem, then we'd say "ok, what do we do about that?" and I'd say "ok, who's going to do that by when?"…. That goes into the record… And then [call them] to account "why haven't you done it? You said you were going to do it, you know, it's now past the deadline. I don't want to see this again next time. You know, what are you going to do?"

These frequent review meetings, the act of pinning the performance report on the door of the managers' office and of naming the managers responsible for corrective actions and of calling them to account for their designed action sent a clear message across that performance matters and helped the Trust to keep on track regarding the performance targets.

In the Hospital B the performance control capability in the early 2000's had been influenced by the absence of systematic practices to perform the performance control function of the Trust: "there were no regular routine meetings between the clinical directorate team and the top of the office….So the sort of structure...where we would have directorate meetings twice a year, big round table meetings, an organised agenda, the data on the table, the performance, the targets, the requirements, you know, performance management, that just didn't happen."

It was not until the arrival of Paul Elton that the performance control capability started to be built. The three functions that needed to be effectively performed if the organisation is to successfully control its performance were operated by the establishment of the frequent performance meetings (the "do or die" meetings in the surgical division). As shown in the narrative, participants of these meetings were charged to identify and produce information regarding key performance variables, and propose actions to respond to adverse performance feedback. The effect of the actions on the performance against the critical performance variables was then checked in the following week's meeting and, in the case of an unsatisfactory result, new actions were then proposed until a satisfactory level of performance was reached.

However, such an arrangement was dismantled with the departure of Paul Elton. During Robert Evans's term the operation of the performance control function was re-established, though through less intense and frequent meetings. During this period there were some attempts to define and elaborate the performance information system through the creation of the "balance scorecard":

> "we got external people to come and tell us what the Hospital B scorecard is, looked at industry, we looked at best practice and we had a planning team and information team producing drafts of what it might look like, i.e. how we're going to measure things, how we're going to report them, you know and we spent quite a few months actually just perfecting that and within the organisation we get comments through. And then agreeing at what level they're going to be pushed down to, so we sort of started at management board and then at divisional board, and then it was up to the divisions then to see if they were going to take them into direct routes."[67]

The requirement of responding to performance feedback was operated through the performance review meetings, which occurred in three instances: the monthly board meetings; the quarterly performance management meetings, and less formal meetings with divisional managers, headed by the Director of Operations, on a more "exceptional" basis. However, due to the strong financial pressure, the priority of corrective action was attached to achieving financial balance and most of the managers' energy and attention was placed on this purpose.

7.4.2. Financial control

Improving the financial control capability is a cornerstone in the recovery and renewal process, particularly when an organisation's financial situation is taken into account during the evaluation of its performance. Without a sound financial control capability, an organisation will be unable to pinpoint the activities and process in which it is losing money, thereby preventing it from implementing more effective corrective action to improve its financial results (c.f. Slatter, 1984). Indeed, a poor financial control capability has been considered as one of most common characteristics of

[67] Interview with Robert Evans.

declining organisations (c.f. Slatter, 1984; Grinyer *et al*, 1988; McKiernan, 2003). Similarly, studies on the recovery of organisations have pointed to the ability to perform the function of finance control as a crucial element of the recovery process (*e.g.* Slatter, 1984; Grinyer *et al*, 1988; Grinyer and McKiernan, 1990; Poister and Larson, 1988; Stopford and Baden-Fuller, 1990; Bibeault, 1982; Balgobin and Pandit, 2001). Fredenberger *et al* (1997) indicated that timely financial information is directly or indirectly used to improve the cash flow when companies are in financial crisis. In NHS organisations, Protopsalitis *et al* (2002) empirical study of recovery of hospital trusts found that performance improvement was associated with a better understanding of the organisations' financial situation and the use of more realistic and sound budgeting practices.

To have a finance control capability means that an organisation has an ability to successfully perform the following component functions: making sense of cost and income; practicing finance planning; and practicing execution control. A capacity to effectively perform these component functions is a crucial requirement to turn the performance of a 'failing' organisation around. This capability was present in both HOSPITAL A and Hospital B, though starting to be developed at different point in time. Both Trusts managed to recover their financial situation after a period of considerable financial deficit. The successful operation of these component functions in both HOSPITAL A and Hospital B can be traced to a set of similar process design features and contextual factors.

The requirement of 'making sense of cost and income' was largely satisfied by two process features: the bottom-up budgeting exercise and the service coding exercise. The bottom-up budgeting exercise carried out in the Hospital B during Robert Evans' term started to paint a more realistic picture of the cost of the budgetary units. As shown in the narrative, this exercise provided the information that served as the basis for the formulation of a more realistic budget for approximately 400 cost centres. The service coding exercise refers to the registering of all services episodes carried out in the Trust and served as a unit of measurement for income generation. By improving the coding of the services episodes delivered by the Trust, it was possible to have a more accurate and precise picture of the potential income generation of the organisation units:

"There were one third of a year's episodes that were not coded, so you're giving up a huge amount of money….As payment by results was coming in, so what we did was putting a proper coding team in [to code the services that had not been coded]...Now, we have by the end of each month everything up-to-date. 5 days after the end of the month everything is coded. And that enabled us early on to grab the maximum income we could*".*[68]

The coding exercise enabled the Trust to make sense of the potential income of the services delivered by the Trust*:* "there were 10,000 uncoded episodes which meant that we didn't know [the actual income generated by the units]. A lot of these patients weren't even registered on the system any more. They're uncoded. So we moved in the first year from 10,000 uncoded episodes to actually balance coding in real time, within a week, or two. And that did have a big impact; that did have an impact on our income*."*[69]

Another interviewee in Hospital B also recalled:

"When Jake and Robert started we see in terms of inpatients about 60,000... probably nearer 80,000 people go through the beds and a quarter of them were uncoded, which meant we didn't know what we'd done to them so therefore we didn't know what to charge. So a quarter of an annual years work was uncoded."

The effect of the coding exercise on making sense of the income position and potential of the Trust was enhanced by a contextual factor: the introduction of the "payment by results" policy of the central government: "In 2004 onwards there was the implementation of a system called Payment by Results where you got paid for what you did. So, all of a sudden what you did and what you coded became the currency by which we sold our products, or services… So yeah that had a massive effect and one of the big things as part of the original financial recovery was an identification of the fact that we were expensive, as a Trust in 2004 we had a reference cost index of 110 which meant we were 10% more expensive than the average organisation in the NHS in England*".*[70]

The second component function, practicing financial planning, was successfully performed by such a device as realistic budgeting, with saving targets as part of it.

[68] Interview with Jake Russell
[69] Interview with Robert Evans
[70] Interview with an executive director in Hospital B.

Having made sense of the cost and income potential of units, it was possible to establish a realistic aspiration for achievement over time. Hence, in both HOSPITAL A and Hospital B, the budget was grounded on a more accurate informational basis, making it possible to set clear and realistic expectations for each unit: "So what happens is we say what we're going to do in the September time, we say how we'll build the budget, we go round and talk to people all through the autumn, individual accountants going out explain what's happening so that by the start of the new year which begins in April everybody knows what's expected of them, how much money they've got, what they've got to do with it".[71]

Executing financial control, the third component function, is a crucial element of the financial control capability. Having a robust budget system will produce little effect if managers in the organisation are not able to perceive and act upon the need to undertake corrective action during the execution and delivery process. In the instances under analysis, the performance of this function was highly sensitive to process design features, such as an effective accounting system that enabled managers to monitor finance execution and detect deviance:

> "You need an accounting system that tells you where you are and it tells you that quickly. If I can give [budget holders] the budget 5, maximum 10 days after the end of the month, so they know what they have spent. I don't give it to them three months late; it's not going to have value then. I need to give you information as quickly as I can and if they say to me "what is this gone through?" I can look it up on a system and tell them that day straight away. And there's always help there for them. So there should be a proper accounting system."[72]

Two other related process design feature were a regular and interactive control of the budget execution; and making budget holders accountable for their performance: "Every month we will collect all our income, collect all our expenditure, compare that to budget and go through a refining process and we will distribute those around the organisation and say "this is what you said you'd spend, this is what you spent". We then have a team of 6 or 8 people in there and 4 qualified accountants who will go out

[71] Interview with Jake Russell
[72] Interview with Jake Russell

and say "your budgets gone overspent... this month your budget's gone overspent significantly", and part of their month end process will be to go and visit those people".[73]

7.4.3 - Service Delivery

Streamlining service delivery processes is obviously instrumental to gaining productivity in a hospital setting. Such an increase in productivity has a direct effect on key performance variable, notably those impacted by waiting time and waiting lists. Streamlining service delivery entails coordinating the dependencies of resources and tasks along the path of service delivery in order to perform faster and better. Davenport and Short (1990) highlight that it is a characteristic of a production or service delivery process to have intermediate customers and to cross organisational boundaries between organisational sub-units. These characteristics suggest that the effectiveness of the whole delivery process is contingent on the quality with which an organisation manages the dependencies among the individual tasks and resources across the delivery path (*c.f.* Crowston, 1997). Despite these characteristics, studies have shown that many "processes result from a series of ad hoc decisions made by functional units, with little attention to effectiveness across the entire process" (Davenport and Short, 1990: 48). Streamlining the delivery process thus involves coordinating and optimizing the relationship of activities, tasks and resources involved in the entire process. The coordination and optimization of the relationship between activities and tasks that add value to a service delivery or a production process is considered as a central element of a firm's competitive advantage (Porter, 1985).

In the case of NHS organisations, delivering Accident and Emergency service, for instance, involves tasks of different organisational units/specialties, generating potential areas of bottleneck along the patient flow with reflection on the Trust productivity and waiting times (see National Audit Office, 2004). Indeed, the inadequacy in managing the key delivery processes, such as waiting lists, discharge procedures and Accident and Emergency, has been cited as key causes of 'failing' organisations inability to turn its performance around (*c.f.* Protopsaltis *et al*, 2002).

[73] Interview with an executive director at Hospital B.

In the HOSPITAL A this challenge, streamlining delivery process, was satisfied by such devices as inclusive meetings with representative of all units involved in a particular delivery process. In these meetings participants were charged to reflect on the entire path in order to indentify and propose actions to overcome bottlenecks. As Peter Dawn illustrated:

> "we bring people from all around the Trust around a table, so from several different divisions, so for the 4 hour wait we have people from medicine because they manage A&E, we have people from Social Services because they manage discharge, we have people from the medical staff, from the site team who manage the beds from an hour to an hour basis, etc…So I as Chair would say "you know, why do we think there's a problem with flow of patients through this pathway?" and people would discuss it, we'd look at some of the data and we'd agree that something was a problem, then we'd say "ok, what do we do about that?" and I'd say "ok, who's going to do that by when?. And we did the same thing again with cancer… And people seeing the bigger picture, understanding the implications of what they're doing or not doing on the next part of the system. That's been quite important - to understand the flow".

From 2007 onwards, the Trust started to adopt more elaborated techniques to improve the delivery process. The key initiative was the introduction of 'lean thinking'. Lean thinking is a management approach that was initially developed in the manufacturing sector, notably the Toyota production system, and which had spread into the service sector: "we need something that is more sustainable, more long-term, more engaging front line staff. And so, we started to construct this idea that we would kick off on lean."[74]

By the end of the interview process, five pilot projects had been introduced. Early data on the impact of the projects had shown to be promising: "I think we got some early data from eye that showed quite a lot of improvement, initial reduction in complexity processes. We know eye is planning to make it 1/3 less complex than it is at the moment".[75] Such a result increased Peter Dawn's conviction of the potential of lean thinking in improving the productivity and efficiency of the delivery process: "to me

[74] Interview with Graham Rich
[75] Interview with Graham Rich

that will be the key element for our future success. I still think we have a long way to go on improving the organisation. Running the lean thinking through many more of our standard processes that was slick, inefficient, we can do them with lower rate of error, less handoffs. So that's got to be the way that we become operationally more efficient".

The effect of these process design features in streamlining the delivery process was enhanced by a context factor, namely the grouping of the organisational units involved in the delivery of a core process into the same division. Martin Mueller collapsed the traditional clinical directorate structure and created five divisions that reflected the core delivery processes of the Trust. Such a new arrangement helped to pull together all specialties and tasks involved the patient 'care pathway', thereby enhancing the management of the dependencies of tasks and resources among different units/specialties along the delivery process. This evidence is consistent with the research carried out by McNulty and Ferlie (2004) on the implementation of process redesign and reengineering in public hospitals in UK. The authors attributed the cause of failure to implement process redesign and reengineering to the fact that it was introduced within established clinical directorate structure and did not succeed in cross cutting the units boundaries. Hence, they concluded that "process management and process redesign are therefore framed and constrained by an organizational form that reinforces values of clinical specialization and promotes vertical reporting rather than horizontal working" (p. 1403).

In the Hospital B, the first attempt to improve the organisational performance via streamlining the delivery process was made during Paul Elton's term. Paul Elton's approach to improving the performance against the key targets strongly relied on the use of process redesign technique. As in the case of HOSPITAL A, the organisational structure was changed in order to group together all specialties and tasks involved in the core delivery process into the same division, rather than into separated clinical directorates. As shown in the narrative section, during this period there was substantial improvement in the performance of the Trust against the key delivery targets. During the same period, there was also an increase in the financial deficit of the organisation. It was thus difficult to separate the effect of the process redesign from the effect of a simple increase on the Trust's capacity. Anyway, such an arrangement, however, lasted less than a year, and was dismantled after Paul Elton's dismissal.

The use of a process-oriented improvement approach gained traction again recently, with the Hospital B 2010 Change Programme. This programme is strongly focussed on the use of process design as a way to improve efficiency and productivity. A consultancy company specialized in process engineering was contracted to design and implement the changes. Twelve projects were identified and have been implemented during the current year. Some of then were set up to have a direct impact on the key performance targets: "projects 1 and 2 which were around admission discharge and making better use of beds. The key objective is to drive down the length of stay in order to reduce occupancy and to reduce occupancy to allow us to admit the right patient to the right beds in a timely way and what have you. So that's a direct link to the 4 hour performance.[76]

By the end of the data collection, the Trust was undergoing an assessment to measure the impact of the intervention. This activity has yielded positive evidence, which made executive directors optimistic about the impact of the intervention onto the Trust's performance: "in terms of the measure of reducing our length of stay, the length of stay has come down…Certainly yes that is smack bang in to 4 hour emergency target... And in terms of outcomes from the elective project there's very little tangible outcome yet. What is key there is about streamlining patient flow, so yeah we'll get to a position where it should aid delivery of shorter waiting times because it should reduce (inaudible) term visits. So that's smack bang into that one."[77]

7.5. Sustaining performance improvement

7.5.1. – maintaining 'good' managerial and organisational practices.

Stabilizing good managerial and organisational practices entails creating the conditions to sustain the organisational and managerial characteristics that led to performance improvement. Research on sustained organisational recovery has found that maintaining the organisational and managerial features that helped to recover its performance contributes to sustained improvement (McKiernan, 2003; Grinyer *et al*, 1988). Features like sound performance and financial control systems, an effective managerial-clinical relationship, which had been developed to recover the performance

[76] Interview with an executive director
[77] Interview with an executive director

of the organisation, are also instrumental in sustaininng the good performance in the long run. However, the managerial and organisational practices that account for these features are vulnerable to collapse, especially when leadership changes. Stabilizing the practice is thus necessary to provide a 'secure footing' (Barzelay and Thompson, 2005) for maintaining the good features in the long run.

One of the keys to ensuring the continuation of these characteristics was careful succession management after the changes in leadership. When Martin Mueller left the Trust, after leading a considerable transformation in the organisation, Peter Dawn, the Trust's then Chief Operating Officer, succeeded him as the new CEO. Because Peter Dawn had played an active role in the transformation process, such a change was viewed as a way to ensure continuity of the 'good' managerial and organisational practices that drove the performance improvement of the Trust: "Obviously Martin's now left and so that obviously that changes things. We don't know how it's going to change exactly yet, but fundamentally I think Peter's been appointed to just continue what we were doing. So I think fundamentally we're now moving forward."[78]

7.5.2 – Developing sensing capability

Maintaining the good features that led to successful recovery is an important condition for long term success, but it is not sufficient. It is also important that the organisation is able to adapt to a changing environmental circumstances (c.f. McKiernan, 2003). This capacity to adapt to a changing environment has been strongly dependent on the organisation's ability to sense the environment in order to identify needs and opportunities for change (Teece et al, 1997; Teece, 2007). The failure to detect and respond to a changing environment, also known as 'organisational blindness', has been cited as one of the major causes of performance decline (c.f. McKiernan, 2003; Weitzel and Johnson, 1989).

The link between the use of systematic environmental scanning activities and performance has been examined in several empirical studies (e,g, Thomas *et al,* 1993; Daft *et al,* 1988). Systematic scanning of the environment helps the organisation to identify new market opportunities and threats (Teece, 2007; Day, 1994); to implement strategic change (Pettigrew and Whipp, 1991); to increase the sense of controllability of

[78] Interview with an executive director

issues and, consequently, the willingness to act (Thomas *et al,* 1993); and, especially in the case of the public sector, to be attentive to demands and needs of key stakeholders (Bryson, 1995).

In the HOSPITAL A, three process design feature contributed to the development of the Trust's ability to sense the environment: the systematic use of scenarios; the creation of community and business advisory groups; and the increased use of benchmarking. From 2004 the Trust started to use scenario to serve as an informational basis for the formulation of their business planning: "the ability to if you like scenario plan. I think that that is an enormous influence skill, and I do think again that 2004 we've done an awful lot of thinking about the different scenarios. Instead of just thinking "I've got to plan to do this and that's what I'm going to do", we've actually sort of thought about scenarios, what the risks are, what the likelihood of those are and have clear mitigation if those scenarios changed".[79]

The practice of thinking about possible futures had become an integral part of the Trust's day to day work: "that way of thinking is becoming quite embedded in the way we do normal operational business. So someone who's got a fairly small scale change still goes through a little bit of a similar thought process saying "well, you know, loads of patients that all dried up" or you know "Hospital X did this", you know, how's that going to affect it? What would you do?"[80]

Parallel to the use of scenarios, the sensing capability of the Trust was also enhanced by the creation of the stakeholder and business advisory groups. These groups were composed of community people and the business sector with the purpose of advising the Trust's board on strategic issues by bringing fresh information from the external environment. These groups provided the Trust with valuable information regarding community demands and business trends:

> "We established the business advisory group and the consumer advisory group and that was to bring different voices into the trust… That challenged the few directors' perception on how the world really works. So we had property development people challenging us on how we use our state, we had marketing

[79] Interview with an executive director from HOSPITAL A
[80] Interview with an executive director of HOSPITAL A

people talking to us about how we should relate to the community, our customer. So that was quite useful in bringing fresh perspective through the existing directors."

Another interviewee also recalled:

"There was nobody representative on those groups and, as part of the strategy and policy development, they were there to advise the board on whether the policy we're developing and strategies we're going from are sellable in the local community. Do they meet what people want? How could we adjust them so that they do that?...We've also got a stakeholder group that's thinking about what patients and public wanted from us".

Lastly, an important process design feature was the increased use of benchmarking in the organisation. Benchmarking has been regarded as an effective practice for sensing the environment (Camp, 1989). Teece *et al* (1987: 521) suggest that "narcissistic organizations are likely to be impaired".

The increased use and scope of benchmarking practices in HOSPITAL A gained traction after Martin Mueller's arrival and was a crucial part of the behavioural change they sought to bring about in the Trust:

"We've been quite keen at getting people to go outside the organisation because one of the themes has been benchmark and challenge. Benchmark yourself against the best and challenge yourself as to why you're not at that level. So raising people's eyes and getting them to look out. We've got a programme which will work out after I go in terms of building relationships internationally with other similar organisations so that we can actually learn from them over an extended period of time rather than just going on a jolly to see them".[81]

An interviewee illustrated the evolution of the scope of benchmark practices as follows: "We do benchmark a lot… In the early years we never benchmarked, then for a period when we started benchmarking we were benchmarking against Weston, Hospital B and Hospital X, and Hospital B and people like that…then we went into say…"no,

[81] Interview with Ron Kerr

we'll benchmark against other UK teaching hospitals" yeah, and now we actually say "no we don't want to benchmark against [UK's] teaching hospitals, we want to find out which are the best, which are the world class and lets benchmark against them". So it's been quite a journey".[82]

In terms of chronology, such evolution was described as follows: "2000/2003 benchmarking locally…[that was] benchmarking against Hospital X, and [from 2004] Martin got us to benchmark against other teaching trusts, and Peter's now saying to us benchmark against the world's best."

7.5.3 – Building up learning capability

Organisational learning has been considered as the key factor for long-term performance. The organisation's ability to learn in order to adapt to a changing environment "plays a central role in distinguishing failing from surviving companies and lies beneath organisational performance" (McKiernan, 2003). This capability informs the organisation's ability to constantly improve the organisation's existing product, services or processes, in order to perform quickly and better. Such an ability to develop and adapt operating routines has often been referred to as 'dynamic capability' (*c.f.* Teece *et al,* 1997; Zollo and Winter, 2003, Nelson and Winter, 1992). Zollo and Winter (2003) propose that the development of dynamic capability is underlined by the co-evolution of three learning mechanisms: experience accumulation; knowledge articulation; and knowledge codification processes.

Experience accumulation is effectively performed when the organisation has implemented and perfected routines to perform some productive tasks in a novel way. Routines are considered an organisation's 'knowledge depository' (Nelson and Winter, 1992), where the outcome of trial and error learning in the operation of particular tasks is accumulated (Gavetti and Levinthal, 2000). Knowledge articulation is performed effectively when groups in the organisation "figure out what works and what doesn't in the execution of a certain organizational task" (Zollo and Winter, 2003). Knowledge codification is effectively performed when 'understanding of the performance implications of internal routines' (Ibid:342) is translated into 'explicit' knowledge (Nonaka and Takeushi, 1990).

[82] Interview with an executive director

From 2007, the HOSPITAL A started to deliberately invest in the development of knowledge processing routines. One of the keys to accumulating knowledge was the use of pilot projects to perform new operating routines and managerial approaches. Instances of this are the creation of the pilot project to introduce the 'lean thinking' in some operating routines. Articulating knowledge about the new operating and managerial processes was facilitated by the creation of an innovation group and an innovation board, which served as a discussion forum and communication vehicle between the innovation team and the operational and managerial staff. The innovation board met monthly to assess the pilot projects. The requirement of codifying knowledge was effectively operated by the systematic production of manuals and training modules, underlain by a careful assessment and understanding of what worked and why it did so. Lastly, another process design feature that had a positive effect across all the three knowledge processing routines was the investment on training on knowledge management and transfer techniques.

7.6 - Concluding remarks

Throughout this chapter we provided a detailed account of the causal factors from each case study that explained the successful performance of each element of the recovery and renewal process. Consistent with 'processual analysis', we explained the success (or failure) of the organisation in satisfying key challenges of the recovery and renewal process by referring to features of the process and context.

It can be concluded from this analysis that organisational recovery and renewal is highly sensitive to managerial interventions that: create collective leadership; foster an action-oriented culture; secure clinician engagement; foster a supportive external environment; strengthen functional capabilities, especially performance control, financial control and service delivery (coordination); build up the organisation's sensing and learning capabilities; and ensure maintenance of good managerial features over time.

Our analysis of the HOSPITAL A and Hospital B revealed that, depending on the context, some managerial interventions have considerable potential to satisfy the above mentioned requirement to recover 'failing' organisations and sustain good performance in the long run. The results of the analysis are represented in Table 6.1.

The first two columns represent a component function of the recovery process that needed to be successfully performed if the organisation is to turn its performance around and sustain good performance in the long-run. The other columns show the process design features and context factors that contributed to the outcome of the specific row's component function.

While this framework sheds light on the causal factors that explain success of failure of recovery and renewal attempts, drawn upon empirical evidences of the two cases studies, it notably takes the form of prescriptive claims. By doing so it incorporates the limitation of any prescriptive model. Indeed, many scholars have stressed that the factors of success of an organisation's performance can be organisation-specific, industry-specific and time-specific (c.f. Porter, 1984). Ghoshal (2005) points out that prescriptive claims have typically the sin of "pretence of knowledge" (term borrowed from Hayek, 1989), which denies other aspects that influence the phenomena under analysis, and almost always result in "bad theory" with potential to destroy good management practice.

Nevertheless our ambition is not to provide a 'scientific law' of organisational recovery and renewal of organisation. Out intention was to provide a holistic view of the process, which encompasses most of the challenges managers in similar situation have to face. Such a holistic framework helps to "identify the relevant variables and the questions which the users must answer in order to develop conclusions tailored to a particular industry and company" (Porter, 1984: 98). Therefore, it could advisedly serve as 'food for thought' (Barzelay and Thompson, 2005) in the process of designing intervention aimed at the recovery and renewal of a failing organisation.

In the next chapter we broaden our analysis of the determinants of recovery and renewal by presenting the findings of a national survey of all acute hospital trusts in England. The purpose of the survey was to form a statistics basis that enabled us to test out and generalize our emerging model. This quantitative analysis will demonstrate the extent to which the satisfaction of the aforementioned functional requirements is significantly associated with performance improvement and long-term performance of the hospital trusts.

Table 7.1 – Explaining recovery and renewal

Component function of the recovery and renewal process	Sub-components		Key process features (HOSPITAL A and Hospital B)	Key context factor (HOSPITAL A and Hospital B)
Creating capability for change	Creating collective leadership		- Creation of the post and appointment of a COO and Medical Director committed to change. - use of selection process to select of the best 'levers' to head the five divisions - leadership development programme	- Management stability/continuity - Balanced external pressure
	Fostering capacity for action culture		Peter Dawn's dissemination of the notion that 'a variance explained is not a variance managed' - Setting expectation action should prevail in relation to 'justification' Introduction of a "sense or urgency" by Peter Dawn.	
Resolving strategic intent (1)	Securing internal engagement		- Open and constant communication between the COO and key clinicians, in both formal and informal events -the role of influential medical director committed to management (legitimize the managerial agenda among clinicians) - Divisional boards, involving lead clinicians into managerial decisions and planning - 'Strategic' clinicians in leadership position – clinicians with demonstrated leadership and commitment to managerial agenda as criteria to select the head of divisions. - Attribution of threat: "things can change for worse if they don't change their behaviour". - management education (e.g. Keele University management programme, which helped to developed common language)	- Organisational climate of openness and truthfulness - Management stability (relatively continuity)
	Securing cooperative relationship with key external stakeholders		- networking externally: - executive team-to-executive team peer meetings with Hospital X Trust to set up common agenda. - one-to-one meeting with CEOs from key stakeholders, including PCT to sell what the HOSPITAL A was doing.	- the number commissioners. - CEO established informal network and reputation. - management team stability
Enhancing operational and managerial process (building up functional capabilities)	Performance control	- setting performance standard and priorities	- fully understanding how the performance will be assessed and the variables that had a bearing on the performance	- Existing performance indicators set up by central government, against which performance will be assessed. - Management stability - availability of key people leading change - supportive organisational culture - effective managerial-clinical relations
		- making sense of performance data	- More frequent monitoring on specific indicators (ex. Daily reporting on 4 hours emergency waiting). - Introduction of the "target tracker" (information system that emulate the Healthcare Commission's targets and indicators, and provides detailed and updated information of the various targets and performance indicators to key people across the Trust) -- frequent meetings which bring and discuss data on performance and making sure that the people who could do something about it receive the data; -- Reports of the performance of units against the targets, highlighting in red, amber, green on all the key targets and which are pined on the door of all the key managers across the Trust	
		-responding performance feedback	- Reviewing meetings to identify performance deviance, set corrective actions and allocate responsibility for corrective actions and call people to account for their corrective actions in the next performance review meeting. - increased performance accountability – call mangers to account for performance	
	Financial control	- making sense of cost and income	- bottom-up budget setting. - enhancing coding process	- environmental pressure for balancing budget - 'paying by performance' governmental policy - Management stability - availability of key people leading change - effective managerial-clinical relations
		- practicing performance planning	- setting realistic budget and saving plans as part of it	
		- practicing execution control	- emphasis on frequent and detailed monitoring of the execution of budgets (a proper accounting system) - detecting deviance and taking timely action. (in Hospital B this was very interactive)	
	Service delivery	- streamlining processes related to key	- inclusive meetings with all participants in the delivery process (enabling a holistic view of process flow) - application of lean thinking (HOSPITAL A) and	- organisational structure that facilitated coordination

		services delivery	process re-engineering and re-design (Hospital B)	of tasks along the pathway of service delivery
Sustaining good performance	Stabilizing practices		- managing succession (appointment from inside, COO took over CEO position) - maintaining the good practices/characteristics	- Level of environmental pressure - Management stability
	Sensing Capability	generating environmental information	- Systematic use of scenario - Increased use of benchmarking - integrated business plan - Creation of the Community Advisory Group, comprised of community people, to provide advice to the Board on community aspirations and demands. - Creation of Business Advisory Group, comprised of members of business community to provide advice to the Board about economic aspect of the Trust operations.	
		- using environmental information	- robust business planning - Robust business case, underpinning decision making	
	Building up learning capability	Accumulating experience	- use of 'pilot projects' to test new management innovation (e.g. 'Lean Thinking'). Experimentation, learning-by-doing; - benchmarking best practices in hospitals across the world	
		Articulating knowledge	- Creation of the Innovation Group and the Innovation Board	
		Codifying knowledge	-use of KM&T techniques -training section	

Chapter 8 – Quantitative analysis of the association between capabilities and organisational performance

8.1 - Introduction and hypothesis

Our findings from the literature review and qualitative analysis carried out in the two case study organisations identified nine capabilities crucial to recover and renew organisations for sustained good performance. In the organisational capabilities literature these capabilities can be classified into three groups, according to the nature of the intangible assets that make up the capabilities, namely Positional Capability, Functional Capability and Cultural/Organisational Capability (cf. Hall, 1993; Coyne, 1986).

Positional capability comprises the intangible assets an organisation "owns", such as brand name and reputations. It is usually the result of past actions, decisions and circumstances that conferred the organisation a certain differential (Hall, 1993; Coyne, 1986). In this research, the supportive external environment is the intangible asset that confers the hospital trusts a positional capability.

Functional capability refers to the ability to perform some individual functions, such as production (or service delivery) (Ibid). It results from the competence of employees in performing these functions. What distinguishes this capability is a set of interrelated processes that need to be evoked to perform a particular function. In this research this type of capability is represented by the performance control capability, coordination capability and learning. What these three capabilities have in common is that they are all underlined by a set of precise processes that are used to perform their respective organisational function. For instance, performance control capability can be said to be underlined by three processes, namely setting standards, monitoring/reviewing performance information, and responding to performance feedback (c.f. Simons, 1995). It is by the operation of these three processes that the performance control capability can be seen and put into use. The operational definition of the four capabilities used in this study, including the precise processes that underlie them, is described in the next sections.

Cultural/organisational capability refers to the intangible assets that apply to the organisation as a whole (Hall, 1993). It is related to the "habits, attitudes, beliefs and values, which permeate the individuals and groups which comprise the organisation" (Ibid: 610). While the functional capability informs the organisation's ability to perform some individual functions needed to delivery their services more efficiently, cultural/organisational capability informs the organisation ability to react to challenges, to sense opportunities and threats, to change, and adapt to changing environment. In this research this category of capability is represented by an "action-oriented culture", "a collective leadership", "effective managerial-clinician relationship" and "a sensing capability". All these capabilities, taken together, inform a Trust's ability to sense the need to, and implement strategic changes in order to adapt to their environment. This type of capability represents what Ciborra and Lanzara (1990) call "formative context", under which new capabilities can be developed. Table 8.1 below represents the three types of capabilities

Table 8.1 – types of capabilities found in this research

Functional Capabilities	Performance control capability
	Coordination capability
	Learning capability
Organisational/cultural capabilities	Availability of key people in leading position across the organisation (hereafter 'collective leadership')
	Action-oriented culture
	Effective managerial-clinician relationship
	Sensing capability
Positional capabilities	Supportive external context

In this chapter we are interested in assessing the impact of the above mentioned capabilities on the organisations' performance. A crucial question is to what extent the use of those capabilities differentiates a 'good' organisation from a poorly performing one? In other words, is the presence of the above mentioned capabilities associated with performance?

Furthermore, a growing literature on complementarities suggests that the performance of an organisation is influenced by the complemetarity, or fit, among the distinct organisational elements (Milgrom and Roberts, 1995; Ichiniowski *et al* (1997);

Whittington *et al*, 1999; Massini and Pettigrew, 2003). According to this literature, organisations implementing a full system of integrated elements are more likely to improve performance. Conversely, partial or piecemeal implementation is said to deliver little, or might be even detrimental to, performance. In this chapter we provide an analysis of the effect of complementarities among the capabilities on trust's performance. To what extent are the capabilities complements, in the sense that the performance contribution of one capability (or type of capability) increases with the presence of the others? In other words, are organisations scoring simultaneously high in the three above mentioned types of capabilities more likely to improve their performance? Conversely, is partial or piecemeal adoption of these capabilities detrimental to performance of the organisation?

In order to answer the above mentioned questions, we apply quantitative methods over a national statistical basis to measure the association between the above mentioned capabilities and the performance of the organisation, as well as to test the link between complementarities among these types of capabilities and performance. The theoretical underpinning of the link between these elements and performance has been provided during the previous chapter, by relying on both relevant theory and empirical evidence from the two cases. The hypothesis derived from our analysis can be summarised in the box below.

H1 - the availability of collective leadership, i.e. leaders in key position across the organisation, is positively related to performance;

H2 – an action-oriented culture among managers is positively related to performance;

H3 – an effective managerial-clinician relationship is positively related to performance;

H4 – performance control capability is positively related to performance;

H7 – coordination capability of the core delivery process is positively related to performance;

H8 – sensing capability is positively related to performance;

H9 – learning capability is positively related to performance; and

<u>On Complementarities:</u>

H10 – the presence of the three types of capabilities, in combination, will be more associated with higher performance than partial presence of these types of capabilities (from the notion of complementarities).

8.2 - Concept and research on complementarities

Research on complementarities has been built on the seminal work of Milgrom and Roberts (1990, 1995). Milgrom and Roberts' work has provided both conceptual and econometric models to the analysis of complementarities among organisational elements. At the conceptual level, Milgrom and Roberts present a notion of complementarity as 'doing *more* of one thing *increases* the returns to doing *more* of another' (emphasis in original) (Milgrom and Roberts, 1995: 181). Elements of the organisation (*e.g.* activities, processes) were said to be complements if the marginal effect of one of them is increasing in the levels of the other elements. In practical terms, they observed, best performance comes from coherence and fit among organisational elements of strategy, structure and processes.

On the mathematical front, Milgrom and Roberts (1995) provided an econometric model, drawing on lattice theory and the notion of supermodularity, to analyse the complementarities among organisational elements. In particular, they examined the complementarities among strategies and structure involved in the transformation of mass production to the 'modern', lean paradigm.

A lattice (X, ≥) is described as 'a set X with a partial order ≥ with the property that for any x and y in X, X also contains the smallest element under the order that is larger than both x and y and the largest element that is smaller than both' (Milgrom and Roberts, 1995: 181). The smallest element is denoted as $x \vee y$ (read 'x join y') and the largest element is denoted as $x \wedge y$ (read 'x meet y'). Then, a function f is *supermodular* and its arguments are complements if and only if for any x and y in X:

$$f(x) - f(x \wedge y) \leq f(x \vee y) - f(y).$$

It is through the notion of supermodularity that the intuitive idea of synergies and systems effects, that 'the whole is more than the sum of the parts', comes to be formalized (Ibid: 184). In mathematical terms, supermodularity is 'equivalent to the statement that for every such x and y, the gains from increasing every component from y_i to x_i is more than the sum of the gains from the individual increases' (Ibid: 185). This statement can be mathematically demonstrated as follows:

$$f(x) - f(y) \geq \left[\sum_{i=1}^{n} f(x_i - y_{-i}) - f(y) \right]$$

The Milgron and Roberts' model has spurred several empirical studies that apply an econometric model based on the notion of supermodularity to analyse the link between complementarities and organisational performance. These studies have typically sought to find support for complementarities by analysing the performance implication of implementing a complete versus partial set of activities (Porter and Siggelkow, 2002). A notable study in this line is Ichniowski *et al* (1997), which demonstrated the performance contribution in terms of productivity of implementing a complete set of HRM practices versus piecemeal implementation of individual HRM practices. Analysis of complementarities was carried out by looking at the performance contribution of four systems representing a combination of HRM practices in a hierarchy from most 'traditional' to most 'innovative'. Elements representing the innovative HRM practices are gradually introduced from system 1, which contains no innovative practices, to system 4, which contains all elements that characterize innovative HRM practices. Regression analysis showed evidence of complementarities among HRM elements. As they put it: "when variables for individual HRM practices are added to the regressions containing HRM system dummies, the individual practices have no additional impact on productivity. In other words, the HRM system dummies capture the full productivity impact of the [production] lines' HRM environments" (Ichniowski *et al,* 1997: 309).

Following Ichniowski *et al* (1997), Whittington *et al* (1999) examined the performance implication of systemic changes involving structures, processes and firm boundaries versus individual changes to one of these elements. Similarly to Ichniowski *et al* (1997), they proposed four system (dummy) variables reflecting changes in all these organisational dimensions. System 1 combined changes to all of these three dimensions and the other systems reflected partial combination of these dimensions. Consistent with the notion of complementarities, regression analysis containing systems and individual changes showed that individual changes had a limited performance benefit, while only systems representing a full set of changes were positively associated with high performance. They concluded by confirming the benefit of the comparison of disaggregated and aggregated types of change, developed by Ichniowski *et al* (1997) as

a useful way to check on the performance contribution of individual practices versus a complete set of configurations.

More recently, working on the same survey of Whittington *et al* (1999) and applying Ichniowski *et al*'s (1997) approach of comparison of aggregated and disaggregated types of change, Massini and Pettigrew (2003) analysed the effect of multiple, systemic *changes* in the three above mentioned organisational dimensions on *changes* on corporate performance. Massini and Pettigrew's (2003) analysis differs from Whittington *et al* (1999) in that they capture the dynamic relation between complementarities and performance – *i.e.* the effect of complementarities of changes to the independent variables (changes in organisational structure, processes and boundaries) on changes to the dependent variables (performance improvement). Similarly to the previous studies, four systems of variables were created, of which system 1 combines changes in all of the three organisational dimensions and the others represent partial aggregation of changes of the organisational dimensions. Regression models of changes in corporate performance containing both the systemic and individual changes were estimated. The results provided supporting evidence of the complementary effect of organizational changes on changes in corporate performance: System 1 increased the probability of corporate performance, while the adoption of partial systems was not significantly associated with performance improvement, and some individual organisational changes had even a detrimental effect on changes in corporate performance.

In this research we follow Ichniowski *et al* (1997), Whittington *et al* (1999) and Massini and Pettigrew (2003) to provide an analysis of the link between complementarities and organisational performance. As described in the previous section, we are interested in checking the performance implication of having a system, which combines the three dimensions (organisational capabilities, positional capabilities and functional capabilities), versus systems representing partial combination of these elements.

8.3 – Measurement Developments

The measurement of the independent variables used in this statistical analysis was drawn from questions in the survey questionnaires sent to directors and CEOs of all

public hospital trusts in England. In order to ensure validity and reliability of the measures used in the questionnaire, we followed the steps and procedures recommended by Churchill (1979), Schwab (1980), Hinkin (1995), Clark and Watson (1995) and DeVellis (1991). Accordingly, we employed the following general steps: (1) precise and detailed conceptualization of the constructs; (2) comprehensive and careful item generation; (3) establishing the content validity (4) pilot study and subsequent refinements (5) full evaluation of reliability and construct validity. This section proceeds by providing detailed discussion of each of these steps.

8.3.1 - Conceptualization of the constructs.

A precise and detailed definition of the construct domain is a critical first step for the development of good quality measures. It involves providing a clear delineation of what is included and what is not included in the definition of the construct (Churchill, 1979). Being exact in the definition of the construct is *sine qua non* for a precise identification of what we want to measure, as well as the sample of items that will be used to measure it.

We satisfied this requirement by presenting for each construct a precise definition and a delimitation of what is included in the definition. The definition of all constructs was grounded in the substantive theory related to the construct. A list of the constructs, along with their definitions is provided in the next section. The following description of a construct definition (performance control capability) serves as an instance on how we defined all constructs used in the questionnaire.

We provided a definition of performance control capability as follows: "an organisation's ability to identify and set targets/standard for critical performance variable; monitoring performance against critical performance variable and responding to performance feedback" (Ouchi, 1977, 1979; Simons, 1995; Hofstede, 1981 and Green and Welsh, 1988).

Functional capability has been defined, in general, as an organisation's 'ability to perform an organisational task or activity' (Hall, 1993). Thus, it is clear from the above definition of performance control capability that we want to measure a functional capability, precisely the "performance control" capability of an organisation. In our

literature review we use a conventional definition of capability as an ability to perform some relevant tasks. Hence, crucial to operationalizing the concept of a capability is the precise identification of the tasks which need to be successfully performed if an organisation is to have this capability. By referring to the literature on performance control, notably those related to cybernetic control, we identified the tasks involved in controlling the performance of the organisation, namely setting standards, monitoring progress in achieving the standards and responding to deviance. The ability with which an organisation performs all these tasks makes up the concept performance control capability. Hence our definition of the performance control capability clearly delineates all the key abilities involved in the process of performance control.

8.3.2 - Item generation.

It is a prerequisite of content validity that the measures capture all the specific domain of the construct and contain no 'extraneous content' (Hinkin, 1995). By having a clear definition of a construct's domain, we were able to select a pool of items that spanned all the content area. In selecting the items to measure the constructs, we sought as far as possible to use questions from existing questionnaires in the literature. When it was not completely possible, items were developed to capture all the domain areas of the constructs.

To continue using the above mentioned example, items to measure 'performance control capability' were selected to capture the three domains of the constructs, namely: ability to set standards ('we are effective at setting goals and targets regarding the performance of key activities'), ability to monitor performance ('we have an effective information system that allows managers to judge their progress towards meeting goals and targets'); and ability to respond to performance feedback ('we ensure that managers receive feedback on whether they are meeting expectation on achieving goals and targets').

Another area of concern in selecting the items is the size of the item pool of each construct. On the one hand, a few items might overcome the problem of response bias, but might lack content and construct validity and internal consistency (Hinkin, 1995). On the other hand, too many items might improve the validity and reliability, but might create respondent fatigue and, consequently, reduce response rate (ibid). There is no

universal rule on what pool size should be considered as adequate. Nevertheless, a review of the 'best practices' in scale development suggest that scales comprised of around five items might be considered adequate (c.f. Hinkin, 1995). Hence, in determining the size of the item pool we followed the 'best practices' suggestion. Accordingly, the size of the item pool used to measure each construct ranged from two to seven items.

As important as the sample size is the 'writing' of the items (Clark and Watson, 1995). Important advice on writing the items is to use a language compatible with the respondents' education and background (DeVellis, 1991; Clark and Watson, 1995). In this research the use of the language was targeted towards people at management executive level. In hospital trusts, however, the remarkable difference in the directors' background (*e.g*. medical director and financial director) can potentially create a problem of comprehension. To overcome this potential problem, all managerial jargon was avoided in the items. Furthermore, as we will see later, we carried out a pilot test with directors with different backgrounds to ensure that the language was clear and comprehensible.

In writing the items we were careful to avoid potential sources of ambiguity, such as long sentences and 'double-barrelled' items (*c.f.* DeVellis, 1991; Clark and Watson, 1995). Reverse-scored items were deliberately avoided due to the potential to induce systematic error and reduce the validity of the questionnaire responses (*c.f.* Hinkin, 1995; see also DeVellis, 1991).

8.3.3 - Definition and operationalization of the variables

Collective Leadership. This construct is defined as the availability of people with demonstrated leadership capacity in key, linking positions at both operational and executive levels (Pettigrew *et al,* 1992; Pettigrew and Whipp, 1991). The measure of this concept was derived from two items in the questionnaire (items 1.1-1.2).

Capacity for Action. We defined capacity for action as the managers' propensity to act in the face of adverse performance feedback or new opportunities. Capacity for action captures: the willingness of managers to question their view of the environment and their organisation (Webb and Pettigrew, 1999); the degree to which they possess a bias

for action (Webb and Pettigrew, 1999; Grinyer *et al*, 1988); and the degree to which they see the causes of the organisation's performance as controllable (questionnaire items 2.1-2.3).

Managerial-clinician relationship. Managerial-clinician leadership captures the engagement of clinicians with the managerial agenda and the extent to which managers involve clinicians into the decision making process (Pettigrew *et al*, 1992). Items 3.1-3.4 of the questionnaire.

Quality of External networking. This variable is defined as the quality of the relationship with key external stakeholders. It was operationalized by selecting a set of key stakeholders from the external environment and asking each respondent his/her opinion about the quality of the relationship with each of these external actors. Based on NHS governance arrangement and drawing on our qualitative analysis of the two cases we identified seven actors as the key external stakeholders: commissioners (PCTs); The Strategic Health Authority (SHA);The Department of Health; Senior managers of other hospital trusts in the region; members of the business community; members of the local community; and patient groups/representatives (items 4.1-4.7).

Performance control capability. This capability is defined as an organisation's ability to identify and set targets/standard for critical performance variable; monitoring performance against critical performance variable and responding to performance feedback (Ouchi, 1977, 1978; Simons, 1995; Hofstede, 1981 and Green and Welsh, 1988). Performance control capability was measured on a 5-item scale (items 5.1-5.3), measuring the extent to which organisations are able to set standards/goals, monitoring progress in achieving these goals and responding to performance feedback. The items were adapted from a questionnaire developed by Challagalla and Shervani (1997) and Jaworski and MacInnis (1989).

Coordination capability of the delivery process. We define coordination capability as an organisation's ability to manage the dependencies of resources and tasks among units and activities within the organisation to deliver the services more quickly and better (*c.f.* Crowston, 1997; Pavlou and Sawy, 2006; see also Teece *et al* 1997 and Porter, 1985). This concept captures an organisation's effectiveness in allocating resources and synchronizing tasks (Pavlou and Sawy, 2006 and Crowston, 1997). The items used to

measure this capability were adapted from the items used by Pavlou and Sawy (2006) (items 6.1-6.3)

Sensing Capability. Sensing capability is defined as an organisation's ability to identify opportunities and needs for change (c.f. Teece, 2007; Day, 1994; Pavlou and Sawy, 2006). It captures the elements of the organisation culture and behaviour that inform its ability to generate and use environmental information. The items in the questionnaire used to measure these capabilities were adapted from the questionnaire developed by Pavlou and Sawy (2006) (items 7.1-7.6).

Learning capability. Learning capability is defined as an organisation's ability to generate and generalize ideas in order to revamp existing operational competencies (c.f. Ulrich and Smallwood, 2004, Pavlou and Sawy, 2006). It captures the following processes: knowledge accumulation through direct experience; knowledge articulation/interpretation; and knowledge codification/dissemination (c.f. Huber, 1991; DiBella *et al,* 1996; Zollo and Winter, 2003; Crossan et al, 1999; Slater and Naver, 1995) (items 8.1-8.5).

Dependent variable

In this chapter we are interested in assessing the impact of the above mentioned capabilities on the organisations' performance. A crucial question is what differentiates a 'good' organisation from a poorly performing one. Performance of the organisation will be measured using the official score for quality of services published in the 2007 Annual Health Check (see Appendix I). Every year the Commission of Healthcare Improvement carries out the Annual Health Check, which assesses and provides an overall score of the performance of the trusts against two performance dimensions, namely 'quality of services' and 'use of resources'. The overall score of a trust against the quality of services has the nature of an ordered discrete variable, measured on a 4-point scale. Performance is scored in the following scale: "weak" (1), "fair" (2), "good"(3) and "excellent" (4).

We have chosen to use the official score available as the dependent variable because it is a good indicator of the key stakeholder perception of the trusts' performance. Boyne and Meier (2009) maintain that measures of whether an

organisation is performing weakly or not should be based on key stakeholders' perception, as opposed to the researcher's perception. In the case of hospital trusts, a key stakeholder in the performance governance system is markedly the central government departments, which impose clear targets against which performance of the trust is assessed. Publication of these results is also accompanied by the media contributing to the dissemination of the perception of failure or success to the broader community based on the official score received by the trust. Performance against the Annual Health Check has wide implications for the organisations' and their managers' reputation. Hence, we believe that the established rating system serves the purpose of this research since it can be considered as a reliable measure of "perceived" performance of the trusts (*c.f.* Fulop *et al,* 2004).

The quality of service dimension of the Annual Health Check is derived from the individual scores against the three components: (1) core standards; (2) existing national targets, and (3) new national targets. Core standard assesses a trust's compliance against the standards set by the Department of Health in relation to seven domains: safety; clinical and cost effectiveness; clinical governance; patient focus; accessible and responsive care; care environment and amenities; and public health. Existing national targets assess the extent to which a trust achieves 12 performance targets. Most of these targets concern patient waiting times in key service areas, such as Accident and Emergency (A&E), inpatient and outpatient waiting time, and cancer diagnosis to treatment waiting time. New national targets measure the performance of a trust against 10 performance targets, measured through 13 performance indicators that seek to capture improvements in some aspects of the health of the served population and the patient experience (*c.f.* Healthcare Commission, 2008).

Control variables

In order to control for the effect of other environmental and organisational characteristics on the performance of the organisations, three control variables were created. First, empirical studies on the public sector have suggested that organisations which reside in areas where economic conditions are favourable have more opportunities to improve their performance than organisations residing in less favourable conditions (e.g. Boyne and Meier, 2009). The environmental capacity to provide needed resources (i.e. munificence) has been considered as an important

influence on an organisation's performance (*c.f.* Dess and Beard, 1984). Organisations residing in areas where needed resources are more easily available are more likely to be successful. Conversely, environments characterized by a scarcity of needed resources can impose higher cost on their residing organisations. We operationalize the scarcity of needed resources as the 'market forces index' used by the Department of Health to account for the differences in 'unavoidable' costs of key resources faced by organisations due to the market forces. Market forces index results from a combination of three indexes which consider the staff wage (staff index), tender price of all public and private contracts (building index), and the price of land in each location of the trusts (land index).[83] Other things being equal it is expected that this index is negatively associated with performance, since the higher the index the higher the cost imposed to the organisations due to environmental forces.

Second, theory and empirical studies have suggested that performance improvement is also influenced by the size of the organisation. Boyne and Meier (2009), for instance, observe that the difficulties in communicating, and gaining support for, a new strategy to a possibly large and dispersed workforce make performance improvement more difficult and lengthier. Thus if we accept that performance improvement is more difficult to achieve in bigger organisations, then it might be also reasonable to assume that bigger organisations tend to have a lower performance level than smaller organisations. We operationalized this variable as the number of staff.

Third, we capture the inertial effect by putting in lags of the performance of the trusts. Thus, we include, as a control, a variable that represents the performance of the trust from the previous period, that is the 2006/07 financial year. In doing so, we are accounting for unobserved historical factors that affect the dependent variable (performance) (Wooldridge, 2006). This implies that some trusts have a traditionally poorer performance than others. Hence, we expect that the performance of the trust in the previous period will be positively associated with the current performance.

8.3.4 - Establishing the content validity.

Content validity refers to the extent to which the item pool is adequate to measure the content domain (DeVellis, 1991; Hinkin, 1995). Cronbach and Meehl

[83] C.f. Department of Health's Technical Work Paper: PbR and the Market Forces Factor

(1955) assert that "content validity is established by showing that the test items are a sample of a universe in which the investigator is interested". In this research, three procedures were taken to ensure content validity. Two of them were described in the previous paragraphs and consisted of clearly specifying the domain of the constructs and generating items that captured the key domain areas of the constructs. Third, the questionnaire was sent for review to four experts at the University of Bath[84]. Experts were given the working definition of the constructs and a copy of the questionnaire, and then were asked the extent to which they thought each item was relevant to the concept we intended to measure (*c.f.* DeVellis, 1991). These three procedures are considered important steps to establish content validity of a construct (*c.f.* Churchill, 1979). Additionally, once the data was collected, factor analysis was carried out to assess the *unidimensionality* of the constructs, that is, whether the items underlie the same dimensions. Analysis of the loading of items on the factors was carried out to identify potential candidates for removal and retention (c.f. Clark and Watson, 1995; DeVellis, 1991). Items loading low on their relevant constructs were removed.

Pilot study and subsequent refinements

Literature on survey research recommends that, if at all possible, a researcher should conduct a pilot study in a sample formed by respondents with similar characteristics of the concerned population (e.g. Bryman and Bell, 2003; DeVellis, 1991). DeVellis (1991: 78) stresses that such a pilot should be conducted in a sample large enough to "eliminate subject variance as a significant concern". In this research it was not possible to administer the pilot study in a large sample of the population. This is mainly because the full study encompasses the entire population of hospital trusts in England. Sending the pilot questionnaire to a sample of this population would imply that we had either to send the questionnaire twice to the same people or to select them out of the population during the administration of the full study. The former would increase the chance of 'respondent fatigue', which could severely reduce the response rate when the full study is applied. The latter might affect the representativeness of the subsequent sample (Bryman and Bell, 2003).

[84] The experts who received the questionnaire for "face" validation were: Professor Andrew Pettigrew; Professor Rod Green; Professor Russ Vince and Dr. Steve Brammer, all of them from the School of Management of the University of Bath.

The next alternative would be to apply to a sample that is 'qualitatively' different from the target population, i.e. to send the questionnaire to a sample of people working in a different kind of organisation (e.g. universities, or schools). Such an alternative is also not advisable, as "the underlying structure that emerges may be a quirk of the sample used in the development" (DeVellis, 1991).

We therefore chose to pilot the questionnaire qualitatively, rather than quantitatively. A group of senior managers of the two hospital Trusts studied in this research were asked to answer the questionnaire in the presence of the researchers. This procedure enabled us to immediately grasp the reactions and difficulties of the respondents in answering the questionnaire. Questions that seemed not to be understood and confusing words were altered.

8.3.5 - Evaluation of the reliability and construct validity.

8.3.5.1 - Construct validity

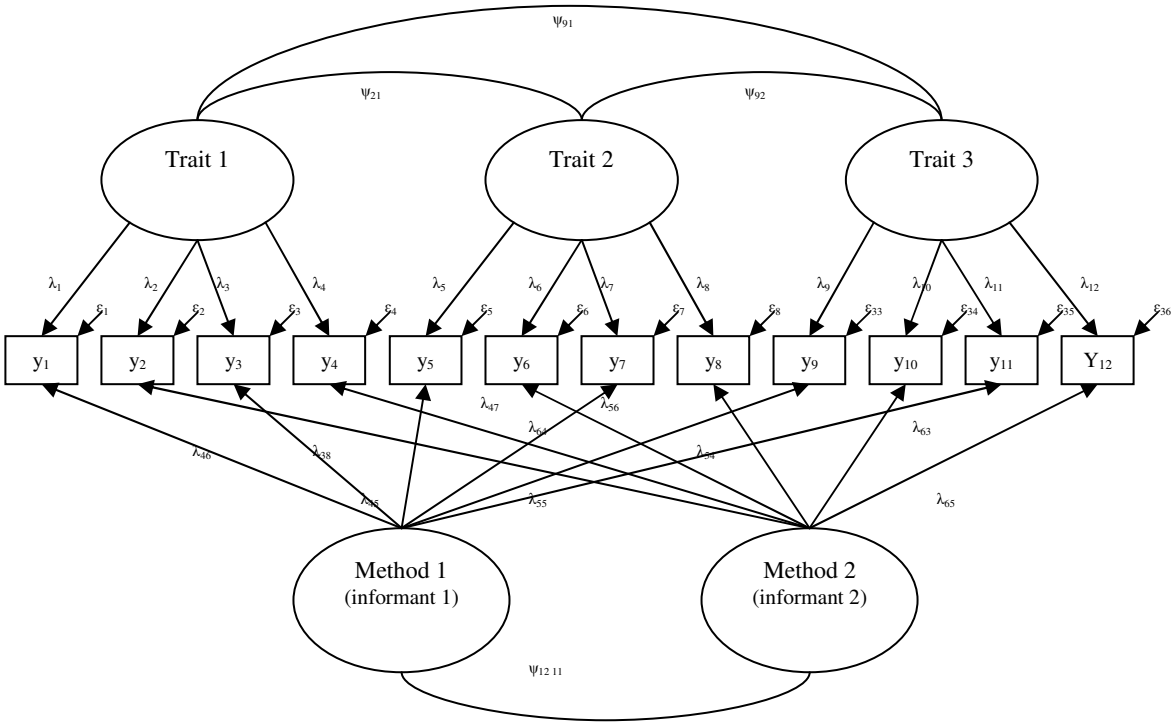
Construct validity captures the extent to which the items selected to measure a concept really measure that concept (*c.f.* Cook and Campbell, 1979). A fruitful way to establish construct validity is to assess the extent to which the items correlate with others designed to measure the same thing, and show a lack of correlation with others that are supposedly not measuring the same concept (Churchill, 1979). The former is known as *convergent* validity and the latter is known as *discriminant* validity (c.f. Campbell and Fiske, 1959).

Traditional methods of judging construct validity involve the correlation of different 'traits' (concepts) when each of them was measured by different methods. Perhaps the most used has been the *multitrait-multimethod matrix* (MTMM Matrix) advocated by Campbell and Fiske (1959). More recent studies have pointed to inadequacies of the Campbell and Fiske's model for unrealistic assumptions and suggested the other confirmatory measurement techniques, such as Confirmatory Factor Analysis or the First-order Multiple-informant Multiple-item mode (FOMIMI) (*e.g.* Bagozzi and Phillips, 1991; Kumar and Dillon, 1990).

Bagozzi and Phillips (1991) argue that Confirmatory Factor Analysis is superior to the traditional MTMM matrix methods because "it makes fewer assumptions and provides more diagnostic information about reliability and validity than Campbell and

Fiske's criteria". The description of the CFA model for three traits and two methods (informants) can be schematically illustrated in the figure below.

Figure 8.1 – Confirmatory Factor Analysis diagram for construct validity



The squares in the figure above represents the measurement and the circles represent the 'traits' or the concepts (upper circles), and the methods, which in this case are the informants (lower circles). The arrows imply the causal influence on the measurement, which can be attributed to the traits, methods or random error. The symbol λ are the factor loadings relating to the 'traits' or methods to the measurement. The curved line connecting the pairs of traits and pair of methods indicates the correlation between them, which is represented by ψ (c.f. Bagozzi and Phillips, 1991).

Since convergent validity is by definition the extent to which a measure of a concept is similar to other measures of theoretically related constructs (DeVellis, 1991), high factor loading and high significance level for the 'traits' can indicate a high degree of convergent validity (Bagozzi and Phillips, 1991; Schwab, 1978; Kearns and Lederer, 2003). Evidence of discriminant validity can be obtained by analyzing the correlation between pairs of traits. A high level of correlation between them would indicate the lack

of discriminant validity. Bagozzi and Phillips (1991) suggest discriminant validity will be achieved when the correlations among traits are significantly less than 1.0. Chi-square difference test is then applied to test the 'goodness of fit' of the model and how well discriminant and convergent validity are achieved.

Despite its sound theoretical ground, such an approach is poorly suited in the case of a small data sample (Hulland, 1999; Fornell, 1982). Anderson and Gerbing (1984) demonstrated that confirmatory factor analysis applied in small sample size can often result in nonconvergent or improper solution. Indeed, an attempt to apply Bagozzi and Phillips' (1991) model to the sample used in this research (n= 226) failed to achieve convergence and resulted in error.

A prominent method to assess construct validity, better suited in the case of small data sample, has been proposed by Fornell and Larcker (1981). These authors suggested that convergent validity can be assessed by looking at the 'composite reliability', *i.e*, the extent to which there is an internal consistency among the indicators that make up the same construct. Internal consistency is concerned with the extent to which the items used to measure a concept are related to each other (DeVellis, 1991; Bryman and Bell, 2003). Composite reliability measure is calculated using the following formula (c.f. Fornell and Larcker (1981)):

$$\text{Composite reliability} = ((\Sigma \lambda_{yi})^2) / ((\Sigma \lambda_{yi})^2 + \Sigma \text{Var}(\varepsilon_i))$$

where λ_{yi} is the standardized loading of the indicator *i* on the construct *y*.

According to this formula, composite reliability can be interpreted as the total amount of 'true' score variance (*i.e.* that does not contain random error) in relation to the total scale score variance. Interpretation of this measure can be made by following Nunnally (1978), who suggest the benchmark of 0.7 or greater as acceptable for establishing content validity. In this research the composite reliability estimates were calculated using structural equation modelling in the software AMOS 16.0 (the steps followed in this calculation is displayed in the Appendix A). The results are displayed in the table 8.2. The composite reliability measure for all constructs exceeded the Nunnally and Bernstein's benchmark of 0.7 for good internal consistency, demonstrating convergent validity.

Table 8.2 – measure of composite reliability (convergent validity)

Construct	Number of Items	Composite reliability
Action-oriented culture	3	0.76
Performance control capability	3	0.77
Coordination capability	3	0.81
Collective leadership	2	0.71
Learning capability	5	0.88
Managers and clinicians relationship	4	0.85
Sensing capability	6	0.86

Still following Fornel and Larcker (1981), discriminant validity can be assessed by looking at the Average Variance Extracted (AVE). AVE is a measure of the 'average variance shared between a construct and its measures' (Hulland, 1999). Discriminant validity is established when a construct shares more variance with its measure than with other constructs (Ibid). Fornel and Larcker (1981) suggested that this condition is satisfied when the AVE of a construct is greater than the square of the shared correlation with other constructs in a given model. The AVE can be calculated as follows (*c.f.* Fornell and Larcker, 1981):

$$AVE = \Sigma \lambda_{yi}^2 / (\Sigma \lambda_{yi}^2 + \Sigma Var (\varepsilon_i))$$

Demonstration of the discriminant validity can be facilitated with the help of a correlation matrix representation suggested by Hulland (1999) (see also Birkinshaw *et al,* 1995, for an application of this matrix). In this matrix, the lower left off-diagonal elements represent the correlations between the different constructs, and along the diagonal are the square roots of the AVE for each construct. Discriminant validity is thus established when the values in diagonal are greater than all other entries in the same line and columns (Hulland, 1999). Table 8.3 shows the discriminant validity matrix for this research. As shown in this table, no entries (correlations between the different constructs) are greater than the corresponding value in the diagonal (square root of the AVE), demonstrating that the discriminant validity was established (the steps followed in the calculation of this value are detailed in the Appendix B).

Table 8.3 – Discriminant validity

	Learn	Action	scan	mc_rel	coord	control	Leader
Learn	**0.777**						
Action	0.499	**0.714**					
scan	0.593	0.612	**0.779**				
mc_rel	0.477	0.638	0.501	**0.763**			
Coord	0.726	0.538	0.552	0.496	**0.771**		
Control	0.599	0.685	0.499	0.604	0.564	**0.723**	
Leader	0.467	0.680	0.563	0.686	0.500	0.590	**0.742**

8.3.5.2 - Item Reliability.

Item reliability refers to the extent to which an item used to measure a concept is related to the concept it wants to measure. Hence, item reliability is assessed by looking at the loadings of the items with their respective construct (Hulland, 1999). High factor loadings indicate a good degree of individual item reliability. In this research all individual item loadings were greater than 0.6, with most of them greater than 0.7 (table 8.4).

Table 8.4 – Individual item reliability[85]

Item		construct	Loading	Item		construct	Loading
Q11	<---	Action	0.774	Q47	<---	Learn	0.712
Q7	<---	Action	0.735	Q46	<---	Learn	0.729
Q10	<---	Action	0.623	Q45	<---	Learn	0.789
Q19	<---	Control	0.763	Q12	<---	mc_rel	0.787
Q20	<---	Control	0.669	Q13	<---	mc_rel	0.809
Q21	<---	Control	0.733	Q15	<---	mc_rel	0.724
Q32	<---	Coord	0.737	Q16	<---	mc_rel	0.729
Q33	<---	Coord	0.793	Q43	<---	Sensing	0.765
Q34	<---	Coord	0.781	Q42	<---	Sensing	0.772
Q4	<---	Leader	0.706	Q41	<---	Sensing	0.804
Q5	<---	Leader	0.777	Q40	<---	Sensing	0.837
Q49	<---	Learn	0.838	Q39	<---	Sensing	0.751
Q48	<---	Learn	0.809	Q38	<---	Sensing	0.738

8.4 Administration of the survey.

A web-based questionnaire containing the items measuring the eight explanatory variables was designed. Items of each question are anchored by a five-point Likert-type scale, ranging from 'none' (1) to 'great' (5). The questionnaires were targeted at the CEO and three directors, namely the financial director, the medical director and the director of operations or equivalent (such as, director of performance

[85] The values of the individual item reliability were 'Standardized Regression Weights', obtained using AMOS 16.0.

improvement or service delivery). The reason for selecting these respondents was fourfold. Firstly, previous research has shown that four informants are sufficient to provide information about organisational characteristics, such as capability and culture (Mannion *et al*, 2005). Secondly, respondents at board level are more likely to have an overall view and knowledge of the organisation's strategy and features as a whole (Gold *et al,* 2001; Snow and Hambrick, 1980). Thirdly, the precise managerial roles selected (e.g. CEO, financial director, medical director) are common in the vast majority of the hospital trusts. Indeed, all hospital trusts are required by law to have a medical director, finance director and, obviously, the CEO. Such standardization is important to prevent the bias derived from having, in each unit of analysis (organisation), informants with distinctive access to information and perspective (*c.f.* Seidler, 1974).

The questionnaires were administrated as follows. Firstly, an introductory letter explaining the survey and giving the URL link to the questionnaire was sent to the CEO and the three above mentioned directors of all hospital trusts in England (see letter in the Appendix C). Thus, a total of 680 introductory letters were sent. This number represents the number of hospital trusts in England (170) times the number of potential respondents in each hospital (4). Secondly, two weeks after sending the letter, an e-mail containing the URL link to the questionnaire was sent to all potential respondents.

We did not have, initially, a database containing the potential respondents e-mail addresses. By looking at the e-mails of some directors and CEOs available on the website of some trusts, we observed that, in general, the e-mail address of the directors and CEO followed a standard format, that is "first-name.surname@domain-of-trust.nhs.uk". For instance, a medical director called Thomas Rowland, working in the Hospital B, would probably have the following e-mail address: thomas.rowland@Hospital B.nhs.uk. Hence, we constructed a database of e-mail addresses by following this rule. Such an approach was successful in most cases. As expected, some e-mails failed to reach the target and bounced back to the sender. In this case, we phoned the respective trusts and spoke with the personal assistants of the directors/CEO in order to obtain their correct e-mail address. We then followed up the responses and sent two "reminders", at an interval of two weeks.

Both the introductory letter and the e-mails contained a short text explaining the importance of the survey. Assurance of confidentiality of responses was also provided

to the respondents. In order to encourage the directors and CEO to respond to the questionnaire, we included in the introductory letter and in the e-mails quotes of influential actors re-stating the importance of responding to the questionnaire and encouraging them to do so. Hence, the letters and emails included a quote of a director of the NHS Confederation, a quote from a director of the NHS Institute and a quote from an influential CEO of a hospital trust (see letter in the Appendix C). Further to increase the response rate, we offered a report summarizing the results of the study as an incentive.

8.5 - Econometric estimation model.

The association between the capabilities and the performance of the trusts will be measured by using an ordered probit model. The reason for using an ordered probit model stems from the fact that our dependent variable is discrete and an ordered, reflecting the official score rating received by the hospital trusts in England for the quality of services dimension. As described above, the overall score of a hospital trust is summarized by a four-point ordinal scale, ranging from "weak" to "excellent". In this case, probit regression model is superior to alternatives, since ordinary least square would fail to account for the discrete nature of the dependent variable, and multinomial logit model (which is also widely used when the dependent variable is discrete and nominal) would fail to account for the ordered nature of the variable (Greene, 2003).

The latent variable specification of the model that we estimate can be written as:

$$y^*_i = \beta_i + \delta X_i + \gamma C_i + \varepsilon_i \qquad (i = 1,\ldots, n)$$

where y^*_i is the unobserved, latent variable reflecting the performance of the trust i in relation to the quality of service (dependent variable); X_i is the vector of explanatory variables, denoting the use of capabilities of the trust i (independent variable); ε_i is the random error; and C_i is the vector of control variables reflecting the influence of the characteristics of the trusts and their environment, such as size, economic conditions of local area, that influence the dependent variable.

In this model we do not observe y^*_i, instead we observe y_i (score in the Annual Health Check) which is derived from the latent variable model by applying the following observation mechanism:

$y_i = 0$ (weak) if $y^*_t \leq u_1$

$y_i = 1$ (fair) if $u_1 < y^*_i \leq u_2$

$y_i = 2$ (good) if $u_2 < y^*_t \leq u_3$

$y_i = 3$ (excellent) if $y^*_t > u_3$

where u_1, u_2, and u_3 are the unknown cut points or threshold parameters to be also estimated, subject to the ordering rule that $u_1 < u_2 < u_3$. The threshold parameters and the magnitude of the effect of the use of capabilities on the performance were obtained by applying the estimation routines available in the computer software STATA 9.0.

In order to avoid biased estimation due to the sampling design, especially due to the fact that we had differences in the number of respondent per trusts (see next section), we estimated the parameters using the 'complex survey data analysis' technique. Failure to account for the sampling design might lead to results that seem to be significant, while in fact, they are not[86]. This is because sampling design, i.e. the number of strata, the existence of clusters and the way the primary unit of analysis itself (e.g. Trusts) and its component elements (directors/ceo) are sampled, affects both the point estimates and the standard errors of the estimates[87].

To account for the sampling design it is necessary to define features of the survey such as the strata, the primary sampling unit, or clusters, (i.e. the first unit which is sampled in the design), and the sampling weight. In this research, we have the following sampling design: firstly we have a sample of trusts (clusters, also called primary sampling unit - PSU). Secondly, within each cluster (trust) we have a sample of respondents (directors/CEO). As we had a different number of respondents per trust (see next section), the sample size of each trust is, therefore, different. To account for this difference, we created a variable "pweight", which weights the observation according to the inverse of its probability of being selected. Thus, for an observation from a trust in

[86] Introduction to Survey Data Analysis with Stata 9. UCLA: Academic Technology Services, Statistical Consulting Group. from http://www.ats.ucla.edu/stat/stata/seminars/svy_stata_intro/default.htm (accessed September 13, 2009).
[87] Ibid.

which only one director responded, this variable will have the value of 4 (the inverse of ¼). This means that this observation represents the four elements from the population from which the sample was drawn (that is the number of directors/CEO that received the questionnaire in each trust, which is equal to 4). Failure to weight the sampling might result in biased estimates[88].

Considering the cluster sampling in the calculation increases the standard errors of the estimates, since it is more likely to have more cluster-to-cluster variability than individuals items variability[89]. In other words, ignoring the cluster will tend to result in standard errors that are smaller than they should be, 'leading to false positives when doing significance tests'[90] .

Therefore, due to the reasons exposed above, an ordered probit model, which also takes into account the survey design features, is the most appropriate way to achieve robust estimation of the association between performance and capabilities. The "do file" commands used in the Stata 9.0 to run the calculation of parameters estimates is available in the Appendix D.

8.6. - Results.

8.6.1 – Analysis of the non-response bias.

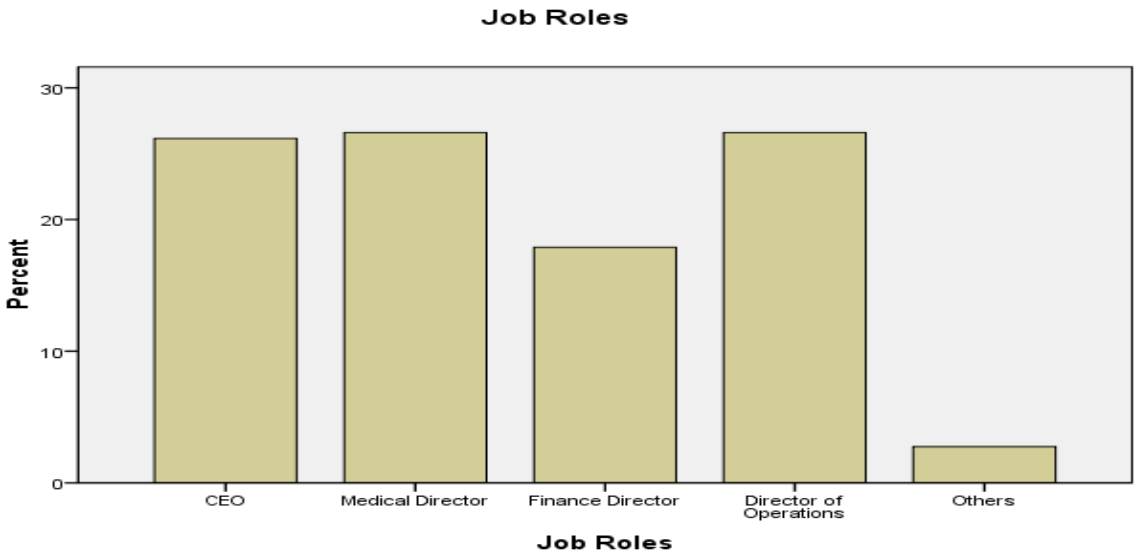
We received 218 responses, representing approximately 75% of the population of hospital trusts in England. At least one director/CEO responded from 127 trusts (75%); at least two directors/CEOs responded from 69 trusts (41%) and at least three or more directors/CEOs responded from 22 trusts (11%). Although we found that a representation of 75% of the trust is highly satisfactory, we conducted a response bias test to see if there were any significant differences in terms of who responded and who did not. Did the lesser performing trusts respond less than highly performing trusts? To answer this question, an independent-samples **t-test** was conducted to compare the trusts' scores in the Annual Health Check for respondents' and non-respondents' trusts.

[88] Ibid.
[89] Ibid.
[90] Statistical Computing Seminars, Applied Survey Data Analysis in Stata 9, UCLA: Academic Technology Services, Statistical Consulting Group, from http://www.ats.ucla.edu/stat/stata/seminars/applied_svy_stata9/default.htm (accessed, September, 13, 2009)

There was no significant difference in the scores for respondents (M = 3.03, SD = 0.77) and non-respondents (M=3.02, SD 0.93); t (167) = 0.059, p = 0.953 (two-tailed).

The percentage of response by functional categories is displayed in the chart below. It shows an equilibrium in the response rates among three (CEO, Medical Director and Director of Operations) out of the four target functional categories.

Figure 8.2 – Percentage of response by functional categories



8.6.2 - Analysis of Informant bias

In this research we gathered data on the organisational capabilities by employing the key-informants method. Questionnaires were sent to three directors and the CEO, *qua* informants, of each hospital trusts in England to obtain data on the extent to which some capabilities are present in the organisation. Such a method has shown to be useful in obtaining information about properties and patterns of behaviour in organisations (Seidler, 1974). However, different characteristics of the informants, such as hierarchical position or gender, can also be a source of bias and lead to 'measurement error' (ibid). In the case of this research, the different job role of the respondents might potentially introduce some bias in measurement of the variables. Does the job role of respondents influence the way they respond to the questionnaire and, consequently, the outcome of regression? Does being in a 'job role' category, say finance director,

compared with being in another category, say director of operations, affect the outcome?

We account for the effect of job role on the outcome by introducing a set of dummy variables based on the respondents' job category. To do so, we firstly decomposed the categorical variables that measure job title into a series of dummy variables. Secondly, we chose the 'director of operations' group, since it represents the majority of respondents, as a baseline (i.e. a group against which all other groups will be compared). Thirdly, we introduced the three other categories in the regression, as control variables. Finally, we applied a 'Wald test' to test whether the introduction of all these variables has no effect or, in other word, whether null hypothesis, that the coefficients for all of these variables are zero, can be accepted (c.f. Long and Freese, 2006; Woodridge, 2006: 249-252). The results of all models used in this research showed that the joint effect of these job categories is not significant (see tables below).

8.6.3 - Regression Analysis of the Association between performance and capabilities

The results of the regression analysis of the association between performance and capabilities are presented in table 8.5. In Ordered Probit models the interpretation of the coefficients is not straightforward. The magnitude of the coefficients cannot be directly interpreted as the magnitude of the effect of the independent variables on the dependent variable, but their sign and statistical significance can be interpreted as in linear regression models (*c.f.* Wooldridge, 2002). Two of the control variables were significantly associated with performance: trusts residing in areas where market forces impose greater cost on key needed resources are more likely to achieve good performance; performance was better in trusts with a good performance in the previous year, demonstrating the importance of inertial effect in explaining an organisation's current performance. Surprisingly, the association between the third control variable (size) and performance was not statistically significant.

As for the explanatory variables, only one, 'sensing capability', was significantly, though slightly, associated with performance (p = 0.065). This result might lead to the conclusion that, contrary to our arguments, an organisation's ability to control the performance of the organisation, coordinate the different activities and learn

from experiences, as well as capabilities like the availability of a collective leadership, an action-oriented culture, a good relationship between managers and clinicians and between directors and external stakeholders, have no effect on the organisational performance. However, it may also be the case that some of the capabilities are significantly associated with performance only when they are introduced in combination with other capabilities. In this case, these capabilities can be considered as complements, in the sense that the performance contribution of one capability increases with the presence of others (*c.f.* Milgrom and Roberts, 1990).

In this research we have elements to suspect that it was not because the above mentioned variables are irrelevant that their effect on the performance was insignificant, but because the performance contribution of one depends on the presence of the others. In other words, we are saying that partial presence of a full set of capabilities have an insignificant, or even negative, effect on performance. Only a complete set of capabilities have a positive, significant effect on performance. Certain capabilities only result in good performance when other capabilities are also present, and vice versa. In summary, we suggest that there are complementarities among the variables used to explain the trusts' performance. Indeed, our qualitative analysis of the case studies showed that the performance contribution of functional capabilities depends on the presence of some organisational/cultural capabilities, like the availability of a collective leadership, an effective relationship between managers and clinicians, and an action-oriented culture among managers, as well as a supportive external environment (a positional capability).

It can be argued, for instance, that the availability of leaders committed to the change agenda in key positions (collective leadership) and an action-oriented culture among managers, helps the organisation to timely respond to performance feedback (control capability) and to anticipate opportunities and threats form the external environment (sensing and learning capabilities). Similarly, the performance effect of functional capabilities, control and coordination capabilities, might be offset by a poor relationship with key external stakeholders, and vice-versa.

In the next section we quantitatively test the extent to which the functional capabilities (control, learning and coordinating), the cultural/organiational capabilities (collective leadership, action-oriented culture, effective relationship between managers

and clinicians, and sensing) and the positional capability (supportive external environment) are complements in the explanation of the trusts' performance. Did the presence of the above mentioned capabilities really increase the performance contribution of the other capabilities? Was the performance contribution of the three types of capabilities factors dependent on the presence of each others? Putting it in another way, were there complementarities among the identified capabilities in the explanation of the trusts' performance?

Table 8.5 – ordered probit estimates of the association of performance and capabilities

quali08	Coef.	Linearized Std. Err.	t	P>t	[95% Conf. Interval]	
controlling	-0.00996	0.0620625	-0.16	0.873	-0.1327992	0.1128791
coordinating	-0.0456641	0.0764518	-0.6	0.551	-0.1969836	0.1056554
sensing	0.0548569	0.0294863	1.86	0.065	-0.0035047	0.1132185
Learning	0.0543585	0.0404562	1.34	0.182	-0.0257156	0.1344326
col_leader	0.0172703	0.083204	0.21	0.836	-0.1474138	0.1819544
act_cult	-0.0195346	0.0564462	-0.35	0.73	-0.1312575	0.0921883
mc_relat	0.0506057	0.0425451	1.19	0.237	-0.033603	0.1348144
ext_relat	0.0591907	0.0374624	1.58	0.117	-0.0149578	0.1333393
size	-0.0000399	0.0000499	-0.8	0.425	-0.0001386	0.0000588
quali07	0.3085191	0.1256521	2.46	0.015	0.0598184	0.5572197
m_factor	-2.597937	0.9432059	-2.75	0.007	-4.464806	-0.7310685
CEO	-0.2234266	0.2028513	-1.1	0.273	-0.6249261	0.1780729
Fin. Direc.	0.1353392	0.2245062	0.6	0.548	-0.3090214	0.5796998
Med. Direc	-0.3822387	0.2978525	-1.28	0.202	-0.9717723	0.2072949
/cut1	-0.8707905	1.485733	-0.59	0.559	-3.811472	2.069891
/cut2	0.4368773	1.440731	0.3	0.762	-2.414733	3.288487
/cut3	1.956654	1.44229	1.36	0.177	-0.8980417	4.81135

F(14, 111) = 4.32 Prob > F = 0.0000
Adjusted Wald test for job roles: F(3,122)=1.23 Prob > F = 0.3020

8.6.4 - Analysis of Complementarities and organisational performance.

In order to check the link between complementarities and performance, the individual elements were combined into three new variables representing the three dimensions of analysis: functional capabilities (controlling, coordinating and learning), cultural/organisational capabilities (collective leadership, sensing, effective manager and clinician relationship, and action-oriented culture) and positional capability (good relationship with key external stakeholders). Individual elements were transformed into a series of binary variables, where 1 represents the existence/presence of the certain capability and 0 the absence of this capability. Similarly, the composite variables – functional capabilities and cultural/organisational capabilities - were subsequently

transformed into binary variables as follows: an organisation takes the value 1 for functional capabilities if each of its composing variables takes the value of 1, *i.e.* the sum of its three composing variables (controlling, coordinating, and learning) is three; and it takes the value of 1 for cultural/organisational capability if the sum of its four composing variables (availability of collective leadership, good managers and clinicians relationship, sensing, and action-oriented culture) is four.

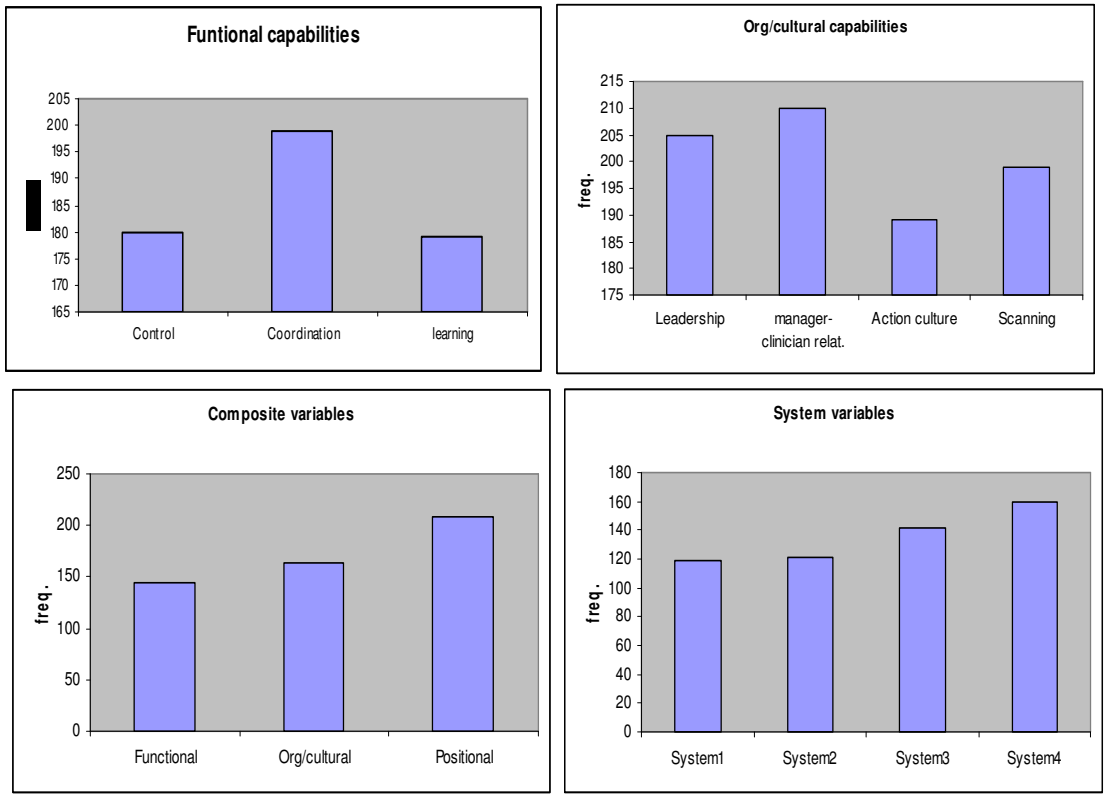
Finally, the three composite (dummy) variables, functional capabilities, cultural capabilities and positional capabilities, were used to create the four possible system variables, as follows: System 1 includes all three composite variables; System 2 combines functional capabilities and cultural capabilities context; System 3 combines functional capabilities and positional capabilities; and System 4 combines cultural capabilities context and positional capabilities. The system variables were also built on a binary basis, following the same rule adopted in the case of composite variables, that is to ascribe the value 1 if, and only if, all the composite variables that make up the system take the value of 1. Thus, system 1 takes 1 if the sum of the three composite variables (functional, cultural and positional capabilities) is three. Accordingly, in the case of systems 2, 3 and 4, a system variable takes the value of 1 if the sum of its composite variables is 2. The composition of all above mentioned variables is summarized in the table (8.6).

Table 8.6 – definition of the individual, composite and system variables

Composite variables	**Individual variables**	**Items**
Functional capabilities	Controlling Coordination Learning	q19 + q20 + q21 q32 + q33 + q34 q45 + q46 + q47 + q48 + q49
Cultural/organisational capabilities	Collective leadership Action-oriented culture Manager & clinician relationship Sensing	q4 + q5 q7 + q10 + q11 q12 + q13 + q15 + q16 q38 + q39 + q40 + q41 + q42 + q43
Positional capabilities	External relationship	q18_a + q18_b + q18_c + q18_d + q18_e + q18_f + q18_g
System variable		
System 1	Functional + Cultural + Positional	
System 2	Functional + Cultural	
System 3	Functional + Positional	
System 4	Cultural + Positional	
Control variables	Size Market factor Previous performance Job role of respondents (CEO, Finance Director, Medical Director)	

The figure below summarize the descriptive statistics on the presence of the capabilities in the sample of trusts in England. As can be seen in the charts, the individual variables, taken individually, are present in more than 82% of organisations for the Functional Capabilities variables (chart 'Functional Capabilities') and 85% for Cultural/Organisational Capabilities variables (chart 'Cultural Capabilities'). When aggregated into the three groups (functional, cultural and positional capabilities), the presence of the functional capabilities type variables is less pervasive, with approximately 66% of organisations reporting the aggregated presence of the Functional Capabilities variables and 76% for Cultural Capabilities variables. High quality of relationship with external stakeholders (positional capability) was found to be widespread across England, with 97% of the trusts scoring high in this variable (chart 'Composite Variables'). Despite the widespread presence of aggregated Cultural Capabilities variables, when combined into the systems variables, only 56% of the trusts combine this with the capabilities variables, as in System 2, and 55% combine with all other dimensions as in System 1 (chart 'System Variables').

Figure 8.3 Descriptive statistics on the presence of capabilities in the sample of organisations



In the table 8.7 we present the results of a set of the ordered probit models for the whole sample of trusts in England[91]. Each model tests the association between performance of the trust and the presence of the capabilities. Following Massini and Pettigrew (2003), for each model we derive a more parsimonious model with significant variables. To do so, we start with a comprehensive model, which includes all variables under analysis, and then we drop the non-significant variables, one by one, starting from the least significant. At the bottom of the table we provide diagnostics (F test) of the joint significance of the variables for all our models[92]. These diagnostics indicate that the variables are jointly significant. As we expected the control variables 'm_factor' and the variable measuring previous performance, 'quali07', remain significantly associated with performance throughout all models, and 'size' has no significant effect on performance.

Columns 'a' and 'b' present the results of the models with only the individual variables included. Column 'a' is the result of the model with the full set of individual variables and Column 'b' is the result of the reduced model, after the deletion process described above. In column 'a', the only positive and significant variable at 0.05 level is 'sensing'. This result is similar to the result obtained from the model displayed in table 8.5, which was estimated without transforming the individual variables into binary variables. After the reduction process (column 'b') 'collective leadership' also becomes positively and significantly related to performance.

Columns 'c' and 'd' display the results for the composite variables. 'Cultural/Organisational Capabilities' was the only explanatory variable that was shown to be positively and significantly (at 0.05 level) associated with trust performance. The deletion process did not change this result, *i.e.* no other composite variable turns out to be positively and significantly associated with performance in the reduced model. The importance of the 'Cultural/Organisational capabilities' variable, however, is reduced after the inclusion of the individual variables (columns 'e' and 'f'). It still remains the

[91] This table format was borrowed from Massini and Pettigrew (2003) and Whittington *et al* (1999). The reason for relying on existing table format, as opposed to creating a new one, was its proven effectiveness in providing a clear way to display and compare the results of all models. We believe that such a uniformity of data presentation also brings benefit for the literature, since it might facilitate future works of comparisons and reviews. Thus, there is no need for reinventing the wheel.

[92] Probit/logit models typically use z statistics and Pseudo R^2 as diagnostic. However, when we use Stata commands that take into account the survey design in the estimation (svy: commands), the diagnostics are calculated using t test and F statistics. Further information about estimations using svy: commands can be found at the Stata Reference Manuals and at http://www.stata.com/support/faqs/stat/svyml.html

only composite variable positively related to performance, but only at the 0.1 significance level. After the deletion process it returns to be significantly associated with performance at the 0.05 level. As for the individual variables, 'sensing capability' is again positive and significant, as in column 'a', but this time only at the 0.1 significance level, while 'manager & clinician relationship' turns out to be significantly, though negatively, associated with performance. This result already indicates some complementary effect among the components of the composite variables. Indeed, the composite variable 'Cultural/Organisational Capabilities', for instance, is positively and significantly associated with performance, whereas its composing individual variables, taken individually, are either insignificant ('collective leadership' and 'action culture') or have a detrimental effect on performance (manager & clinician relationship).

Table 8.7 - Ordered probit estimates of the association between performance and individual, composite and system variables

	Individual		**Composite**		**Indiv. + Comp.**		**System**		**System + Individ.**	
	(a)	Red. (b)	(c)	Red.. (d)	(e)	Red.. (f)	(g)	Reduc. (h)	(i)	Reduc..(j)
System 1							1.713 [0.001]	1.518 [0.000]	2.473 [0.001]	2.317 [0.000]
System 2							-1.094 [0.000]	-0.884 [0.000]	-1.859 [0.001]	-1.751 [0.000]
System 3							-0.172 [0.529]		-0.205 [0.665]	
System 4							0.224 [0.450]		0.303 [0.469]	
Functional Capabilities			0.281 [0.136]		0.450 [0.208]					
Cultural Capabilities			0.578 [0.004]	0.706 [0.000]	0.661 [0.060]	0.576 [0.004]				
Positional capabilities			-0.384 [0.426]		-0.248 [0.635]					
Controlling	0.218 [0.325]				-0.131 [0.630]				0.045 [0.863]	
Coordinat.	0.038 [0.918]				-0.141 [0.733]				0.061 [0.878]	
Sensing	0.872 [0.006]	0.894 [0.001]			0.485 [0.132]	0.559 [0.063]			0.621 [0.039]	0.714 [0.021]
Learning	0.163 [0.527]				-0.168 [0.612]				-0.000 [0.999]	
Collective leadership	0.319 [0.339]	0.563 [0.017]			-0.144 [0.690]				-0.111 [0.765]	
Action culture	0.255 [0.233]				-0.207 [0.510]				-0.242 [0.414]	
Manag. & clinic. Rel.	-0.597 [0.081]				-0.741 [0.006]	-0.541 [0.018]			-0.549 [0.058]	-0.404 [0.047]
External relation	-0.362 [0.465]				-0.248 [0.635]				-0.812 [0.056]	-0.781 [0.006]
size	-0.000 [0.528]		-0.0000 [0.474]		-0.000 [0.430]		-0.000 [0.499]		-0.000 [0.455	
m_factor	-2.625 [0.006]	-2.986 [0.003]	-2.534 [0.006]	-2.659 [0.004]	-2.730 [0.004]	-2.870 [0.003]	-2.552 [0.005]	-2.742 [0.002]	-2.706 [0.004]	-2.940 [0.002]
Quali07	0.396 [0.001]	0.318 [0.009]	0.394 [0.001]	0.344 [0.004]	0.398 [0.001]	0.341 [0.005]	0.413 [0.001]	0.390 [0.001]	0.406 [0.001]	0.372 [0.002]
Job1(CEO)	-.234 [0.314]		-0.109 [0.605]		-0.194 [0.408]		-0.102 [0.624]		-0.203 [0.391]	
Job2(Finance Director	-.016 [0.943]		0.037 [0.868]		-.004 [0.986]		0.122 [0.574]		0.025 [0.913]	
Job3(Medic. Director)	-0.630 [0.044]		-.524 [0.078]		-.588 [0.059]		-0.507 [0.088]		-0.608 [0.056]	
Adj Wald Test for job roles	F(3,122) = 1.65 [0.1815]		F(3,122) = 1.25 [0.2959]		F(3,122) = 1.46 [0.2289]		F(3,122) = 1.45 [0.2311]		F(3,122) = 1.65 [0.1815]	
Observ.	213	215	213	213	213	213	213	213	213	213
F test	F(14,111)=3.68	F(4,122) = 9.60	F(9,116) = 5.22	F(3,121) = 11.49	F(16, 109) = 3.46	F(5,120) = 7.33	F(10,115) = 11.61	F(4,121) = 24.16	F(18,107) = 7.47	F(7,118) = 16.66
Prob >F	0.0000	0.0000	0.0000	0.0000	0.0001	0.0000	0.0000	0.0000	0.0000	0.0000
Cut 1 (std error)	-3.564 (1.207)	-3.228 (1.117)	-3.874 (1.169)	-3.580 (1.067)	-4.855 (1.242)	-3.977 (1.139)	-3.675 (1.121)	-3.731 (1.068)	-4.973 (1.273)	-4.618 (1.140)
Cut 2 (std error)	-2.268 (1.173)	-1.953 (1.071)	-2.613 (1.112)	-2.354 (1.020)	-3.552 (1.203)	-2.719 (1.096)	-2.416 (1.055)	-2.509 (1.023)	-3.652 (1.226)	-3.341 (1.089)
Cut 3 (std error)	-0.779 (1.165)	-0.527 (1.055)	-1.125 (1.100)	-.908 (1.002)	-2.047 (1.196)	-1.260 (1.079)	-0.913 (1.046)	-1.052 (1.014)	-2.118 (1.223)	-1.852 (1.083)

The rest of the table presents the models with the systems variables. Columns 'g' and 'h' display the results of the models that include only system variables. The results in these columns provide supporting evidence to our proposition of complementarities among the capabilities. Only the full set of capabilities (system1) has shown to be positively and significantly associated with performance. This evidence suggests that the performance contribution of the functional capabilities depends on the presence of the cultural/organisational capabilities and the positional capabilities, and vice versa. Partial presence of the types of capabilities under analysis proved to be insignificantly related to performance (system3 and system4) or even detrimental to the trust performance, as it is the case of system2. The negative effect of system2 on performance suggests that the presence of functional capabilities and organisational/cultural capabilities might reduce the performance of an organisation if the positional capability is not also present. This finding is consistent with the literature on public sector management, which highlights the network and political nature of public organisations and the effect of these characteristics on the functioning of the organisations (see Rainey, 1997).

The importance of system 1 is confirmed in columns 'i' and 'j', when the individual variables are reincluded. In both complete and reduced models, system1 is the only system variable to be positively and significantly associated with performance. Although the individual variable 'sensing capability' is again positive and significant, it has a limited effect in comparison to the full system (system1). As we observed elsewhere, the magnitude of the coefficients estimated using ordered probit models have no direct interpretation. It is possible, nevertheless, to understand the relative magnitude of the effect of the explanatory variables on the performance by rescaling the latent variable (y^*) and calculating the standardized coefficients that can be interpreted just like regression models (Long and Freese, 2006).

As mentioned above, the ordered probit models are estimated using linear latent variable (y*), which is unobserved and its metric is unknown. Hence, the marginal change in y* with respect to the independent variables (x_k) cannot be interpreted without using standardized coefficients (long, 1997). The *fully standardized coefficient* can be calculated as follows:

$\beta_{\kappa}^{S} = \frac{\sigma_k \beta_k}{\sigma_{y^*}} = \sigma_k \beta_k^{Sy^*}$, where σ_y is the standard deviation of the latent x_k.

This formula can be interpreted as: "for a standard deviation increase in the independent variable x_k, y* is expected to increase by β_k^S standard deviations, holding all other variables constant" (Long, 1997). Returning to the discussion of the effect of system1 and the individual variable 'sensing' on the performance of the trust, the marginal effect of these variables on *y** is shown in the table below.

Table 8.8- fully standardized coefficients of the effect of the explanatory variables on performance

quali08	b	Z	P>z	bStdXY	SDofX
system1	2.473	3.309	0.001	1.042	0.4979
sensing	0.621	2.086	0.037	0.1495	0.2843

b = raw coefficient
z = z-score for test of b=0
P>|z| = p-value for z-test
bStdXY = fully standardized coefficient
SDofX = standard deviation of X

The effect of system1 on the performance of the trust can be interpreted as each standard deviation (SD = 0.50) increase in the whole set of capabilities (system1) increases performance of the trust by 1.042 standard deviation. In contrast, each standard deviation in the individual variable 'sensing' (SD = 0.28), increases performance of the trust by only 0.15 standard deviation. This analysis reveals that, though the individual variable 'sensing' is positively and significantly associated with performance, it has a limited role in explaining performance in comparison with the whole system variable (system 1), which has a more powerful positive effect over and above its composing elements.

These results fully support our argument about complementarities among the capabilities under analysis: performance of the trust is reduced by the partial presence of the capabilities of the three dimensions under analysis (functional capabilities, organisational/cultural and positional capabilities). Conversely the presence of the whole system of these capabilities increases the performance of the trusts. Therefore, the insignificant association found in table 7.4 when we regressed our individual explanatory variables did not indicate that our theoretical proposition about their association with performance was incorrect, but rather that the performance benefit of one capability depends on the combined presence of the other capabilities.

8.7 - Concluding remarks

In this chapter we presented the result of a survey conducted on the whole population of hospital trusts in England. The purpose of the survey was to obtain a national statistical basis that could be used to measure the association between performance of the trusts and some capabilities. From both theory and the case studies developed over the previous chapter, we identified eight capabilities, which we organised into three categories (functional, organisational/cultural and positional), as important to performance improvement of the hospital trusts. However, contrary to what we had proposed, ordered probit regression models estimated in this chapter indicated insignificant, or even negative, association between performance of the trusts and the individual capabilities we theorized, with the exception of 'sensing capability'.

Using Milgrom and Roberts's (1995) notion of complementarities, and in line with previous empirical studies on this subject, notably Ichniowski *et al* (1997), Whittington *et al* (1999) and Massini and Pettigrew (2003), we explored the existence of complementarities among the capabilities and the relationship between complementarities and performance. To explore the complementarities we derived an analytical framework grounded on the Hall's (1992, 1993) approach, which proposed three categories of capabilities. The individual elements were then combined into three composite variables representing these three dimensions, notably functional capabilities (representing the ability to perform some individual organisational functions), cultural/organisational capabilities (representing intangible assets related to habits, attitudes, beliefs and values, and that apply to the organisation as whole) and positional capabilities (representing the intangible assets that the organisation "owns" and that result of past circumstances that conferred the organisation certain differential, such as reputation and positive image among external stakeholders). The results demonstrated that only when in combination does the presence of these three types of capabilities yield positive and significant association with performance. In other words, the results showed that the presence of the whole system of the capabilities under analysis increases the trusts' performance, while partial presence of the set of capabilities is either not significantly associated with, or even detrimental to, the trusts' performance.

This result provides an additional contribution to the growing empirical literature on the relationship between complementarities and performance. The findings

confirm the importance of complementarities analysis in explaining the performance of organisations. This research represents an original contribution to the empirical literature on both organisational capabilities and complementarities. Regarding the literature on capabilities, it showed that the analysis of the effect of capabilities on performance should incorporate the analysis of complementarities of the different types of capabilities. As for the literature on complementarities, this research provides empirical evidence on complementarities by exploring other configurational elements, such as the different types of capabilities in the context of public sector organisations.

The evidence of complementarities among capabilities examined in this chapter has also an important implication for practice. It suggests that although many organisations might have in place the similar processes that make up the three functional capabilities, it is the presence of other organisational and positional capabilities (here identified as an effective manager and clinician relationship, an action-oriented culture, the collective leadership, sensing, and a supportive external stakeholders) which will ultimately be responsible for differences in the effectiveness of these processes. Hence, in a recovery context, it might be unfruitful to invest in the development of the organisational processes that underlie a particular organisational capability, say control capability for instance, if there is not an investment on other aspects of the organisation that develop other important organisational/cultural and positional capabilities, such as an effective relationship between managers and clinicians and between managers and external stakeholders.

Chapter 9: Conclusion

9.1 – Introduction.

This thesis has examined the process of recovery and renewal of public services organisations. Empirically, this analysis was conducted on the population of hospital trusts in England. Such a population has been subjected to a sophisticated and comprehensive performance management system introduced during the earlier years of Tony Blair's mandate, with the purpose of measuring and bringing about improvement in the performance of acute hospital trusts in England. Under this system all hospital trusts in England had their performance annually measured against a set of centrally pre-established targets, summarized into a single score on a four-point scale, and then published. The CEOs of the hospitals were made directly accountable for the performance of their organisations and some of them were sacked as result of poor performance in the annual performance check. This combination of target and 'threat' created what Bevan and Hood (2006) called a "target and terror performance governance system".

This performance management system worked well by triggering determined efforts from managers of "failing" hospitals to turn the performance of their organisations around and sustain good performance in the long run. Examination of the time series data of the performance of the trusts revealed that some of the trusts that were considered as "failing" organisations during the first few years after the introduction of the performance evaluation system went through a successful turnaround trajectory, while a few others did not achieve sustained performance improvement. This fact raises the issue as to what makes some "failing" organisations capable of turning their performance around and sustaining good performance as a continuous process, while others are not capable of doing so.

Thus far, management literature has been somewhat silent on this issue. As Boyne (2006) observes, efforts of public managers to turn the performance of "failing" organisations around have been made without the aid of comprehensive theory and robust evidence from management literature. It was as a result of recognizing this gap that we posed our four research questions:

Question 1. What capabilities do "failing" public sector organisations need to improve their performance?

Question 2. Why are those capabilities so crucial in explaining performance improvement?

Question 3. To what extent are those capabilities complementary, in the sense that the performance effect of one is increased with the presence of the others/another?

Question 4. How can these capabilities be built and applied?

In order to answer these questions we carried out an in-depth longitudinal case study on two hospital trusts in England: one hospital trust that achieved a successful turnaround after having received three consecutive failing scores; and one hospital trust that went through a rickety and less successful turnaround trajectory. A quantitative analysis was also conducted to expand the findings to the whole population of hospital trusts in England, thereby increasing the external validity of the research, and to provide a statistical basis to precisely examine the complementarities among the capabilities and their effect on the trusts' performance.

In this concluding chapter we return to the research questions and present the findings of the case studies and the quantitative analysis. We will also discuss the main contributions of the thesis to the management literature, described in terms of methodological, theoretical and empirical contributions, as well as the policy and practical implication of its findings. Finally, we examine the limitations of our work and suggest avenues for future research.

9.2 – Findings of the study

9.2.1 – Building capabilities to recover and renew

In this research we looked at the recovery and renewal process of 'failing' organisations through the lens of organisational capabilities. From this perspective a period of consistent poor performance can be regarded as the period in which an organisation lacks the capabilities deemed necessary to turn its performance around. Similarly, a 'failing' organisation's ability to improve its performance and sustain performance improvement as a continuous process is a result of the development and

nurturing of some important organisational capabilities. Our comparative case studies of two organisations revealed organisational recovery and renewal is highly sensitive to managerial interventions that develop the following capabilities: a collective leadership; action-oriented culture; effective managerial-clinician relationship; sensing; performance and financial control; service delivery (coordination); learning and supportive external environment (see chapter 6).

The first four capabilities (collective leadership; action-oriented culture; effective managerial-clinician relationship; sensing) confer on an organisation the ability to react to challenges, to sense opportunities and threats, to change, and adapt to changing environment. Such a kind of capability is often called organisational or cultural capability, as it refers to the habits, attitudes, beliefs and values which permeate the individuals and groups within the organisation (Hall, 1993).

Building a collective leadership refers to the formation of a managerial cadre composed of managers in key leading positions, at both operational and executive levels, who are convinced of, and committed to, the need for change. Such a collective leadership contributes to establishing a climate for change across the different parts and levels of the organisation, creating an internal environment more receptive to change (Pettigrew and Whipp, 1991). At the same time, collective leadership works as key 'nodes' in the complex web of communication in the organisation, helping to disseminate and establish the new vision and values across the different levels and parts of the organisation. Recovery and renewal of organisations require changes in different aspects, parts and levels of the organisation (Baden-Fuller and Stopford, 1996). People in executive and operational positions committed to the change agenda work as the 'levers' for change, which raise the energy level needed to break the inertia and galvanize the organisation's managers and professionals into the action deemed necessary to react to poor performance.

Action-oriented culture highlights the importance of a 'bias for action' among managers as a key element of the organisation's ability to act and respond to adverse performance data and environment information. An action-oriented culture refers to a shared attitude, values and habits by which managers will be far more prompted to 'act' upon adverse performance data, than to find excuses or blame external agents for poor performance. Our research found that the Trust which went through a steady, successful

turnaround trajectory had well-orchestrated team-building to put key 'levers' in the key positions, while at the same time setting the expectation among managers that, in face of poor performance feedback, an action-oriented attitude should prevail over justification or blaming.

An effective managerial-clinician relationship was also found to be advantageous for accomplishing the recovery and renewal of a 'failing' public service organisation. It refers to a pattern of relationships characterized by engagement of professionals with the managerial agenda. In public hospitals, as in most "professional organisations" (Mintzberg, 1983), clinicians exert strong power over the organisations' operations and service delivery. Opposition, or even indifference, from powerful consultants or clinicians can result in a strong block on change (Pettigrew et al, 1992). This research found that the degree of engagement of clinicians with the change agenda was a striking difference between the two case studies. Organisations in which clinicians' engagement with managerial agenda is secured are more likely to embark on a steady recovery and renewal trajectory.

Sensing capability refers to an organisation's ability to sense the external environment in order to identify needs and opportunities for change. Effective scanning of the environment helps public organisations to discern present and future scenarios, and consequently be attentive to challenges posed by the environment. Failure to detect and respond to challenges and demands of a (changing) environment has been the major cause of performance decline of organisations, and the subsequent development of this capacity helps the organisation to develop a consistent strategy and to prevent it going into decline again.

The next four capabilities examined in this research (performance and financial control; coordination; and learning) confer on the organisation the ability to manage the service delivery function efficiently. These types of capability can be called "functional capabilities", as they refer to the ability to perform some management functions (c.f. Hall, 1992; 1993).

Performance control capability underlies an organisation's ability to regulate the activities that are crucial to the organisation's performance and, by implication, the output. Such a regulation seeks to engage actors in corrective actions, as specific

responses to performance feedbacks. Having the capacity to identify and understand output variables that are critical to the overall performance of the organisation, monitor the achievement against these variables and respond to the performance feedbacks help managers to keep the desired performance of the organisation on track.

Similar to performance control capability, financial control capability confers on the organisation the ability to regulate the planning and execution of its finance, and, by implication, its financial performance. Without a sound financial control capability, an organisation will be unable to pinpoint the activities and processes in which it is losing money and to implement corrective actions to keep finance on track.

Service delivery capability refers to an organisation's ability to streamline the service delivery process in order to perform faster and better, considering a given amount of resources. Streamlining the delivery entails coordinating and optimizing the relationship and dependencies of activities, tasks and resources along the path of the service delivery. It results in a gain of productivity with an impact on the organisation's performance. In public service organisations, where repositioning is rarely a realistic strategy[93], streamlining the service delivery becomes crucial for the recovery and renewal of an organisation.

Learning capability concerns an organisation's ability to constantly improve the operating routines of its services and processes in order to perform more quickly and better. It emphasises the importance of learning what works and what does not in the execution of organisational tasks in the attempts to improve the performance and sustain good performance in the long run. Organisations with high learning capability are able to constantly accumulate the outcome of trial and error learning in the operation of a particular task and translate it into 'explicit' knowledge that results in continuous improvement of its operational routines.

Finally, the last capability examined (cooperative external environment) has to do with the quality of the relationship between the Trust's managers and its key external stakeholders. This capability can be considered as a kind of "positional capability", since it is a result of specific circumstances that confer on the organisation a certain

[93] A public hospital, for instance, cannot easily close a clinical ward that is running in deficit and substitute a more 'profitable' clinical specialty.

differential that influences its overall performance (c.f Hall, 1992; 1993). Organisations that managed to build a favourable and externally endorsed interpretation of how they should change and operate are more likely to secure financial support and favourable negotiations of goals and deadlines with key external stakeholders.

The effect of these capabilities, taken both individually and combined with one another, on the performance of the hospital trusts was statistically examined in this research and the results will be presented in the next section.

9.2.2 – Complementarities in organisational capabilities and performance

In this research, using quantitative methods, we examined the degree of association between the use of the above mentioned capabilities and the performance of the hospital trusts in England. To obtain a national statistical basis that could be used to measure this association, we conducted a survey on the whole population of hospital trusts in England. This survey provided data on the degree to which the hospital trusts in England have each of the eight of the above mentioned capabilities. We firstly tested the hypothesis regarding the association between the existence of the individual capabilities and the performance of hospital trusts. This analysis revealed that, with the exception of one (sensing), none of them is positively and significantly associated with performance. One of them (managerial-clinician relationship), taken individually, conveys a detrimental effect on performance.

We then moved on to examine the impact of systems of the above capabilities on performance. The performance of organisations is the result of complex and multifaceted phenomena. The theory of organisational capabilities as a source of competitive advantage has sought to identify different dimensions of capabilities and suggested their complementary effect on an organisation's performance. However no study has provided empirical analysis of the complementarities of capabilities, either in public or private organisations, perhaps because of data limitation; gathering data on the existence of capabilities and performance of organisations is by no means an easy task.

Using Milgrom and Roberts's (1995) notion of complementarities, and in line with previous empirical studies on this subject, notably Ichniowski *et al* (1997), Wittington *et al* (1999) and Massini and Pettigrew (2003), we explored the existence of

complementarities among the capabilities and their effect on performance. This notion conveys the idea that "doing more of one thing [activity] increases the returns to doing more of another" (Milgrom and Roberts, 1995: 181). Applying this notion to the organisational capabilities domain, it can be suggested that an isolated capability may require an additional complementary capability if it is to have a positive effect on performance. Thus, we derived several econometric models to measure the association between systems of capabilities and performance. Each system represented a different combination of the three above mentioned dimensions of capabilities (functional, organisational and positional).

The results provided support to the notion of complementarities of capabilities. Only the system representing the existence of the full set of capabilities in the three dimensions (functional, organisational and positional) was positively associated with performance. On the other hand, the development of partial systems of capabilities (organisational and functional; organisational and positional; and functional and positional) was shown to be insignificantly associated, or even detrimental, to the organisations' performance.

This finding implies that having an ability to, say, perform management functions (functional capabilities) yields insignificant or lower returns on an organisation's performance than if developed together with the ability to change and adapt to a changing environment (organisational/cultural capabilities), and/or with the presence of intangible assets that confer on the organisation a positional advantage (positional capabilities) and vice versa.

9.3 – Practical implication of the findings and advice for managers facing recovery and renewal transitions.

Our purpose in developing this thesis was not only to create knowledge that could contribute to the academic literature in the field, but also to provide practical advice to managers facing a similar situation on how to improve the performance of their public service organisations. To meet this objective we deliberately designed our research questions and strategy in a way to enable us to offer both "what to" and "how to" knowledge. Our multi-method strategy, combining the strengths of quantitative analysis with in-depth, longitudinal case studies, provided the methodological apparatus

to answer questions on both "what" capabilities do public service organisations need to recover and renew ("what to" knowledge), and "how" to build them ("how to" knowledge). By doing so, we believe this thesis satisfies what Pettigrew (1997b; 2005: 975) calls the "double hurdle of scholarly quality and relevance" – research that has both scientific quality and practical relevance.

Before presenting the practical implications of the findings it is important to stress, as a note of caution, that the recovery and renewal of public service organisations is a complex phenomenon, which might be context-specific, time-specific and sector-specific. Our intention was not to claim a universal 'scientific law' of organisational recovery and renewal, but to provide a holistic view of key challenges or areas of intervention of the recovery and renewal process. Such a holistic view of key challenges helps managers to identify relevant variables and questions that can be used to draw conclusions tailored to a particular situation (Porter, 1984). Thus, we believe that our findings could advisedly serve as "food for thought" (Barzelay and Thompson, 2005) in the process of designing intervention aimed at recovering and renewing a failing public service organisation. In the following paragraphs we elaborate some of the key practical implications and advice arising from each of the findings of this thesis.

a) Building capability for change is essential in the early stages of the interventions aimed at recovering and renewing an organisation.
b) Creating "collective leadership" is paramount in building up the organisation's capability for change.
c) Fostering an "action-oriented culture" in the management team is advantageous for enhancing the organisation's capacity to change and react to adverse performance data.

Organisational recovery and renewal require, by definition, changes and managerial intervention. However, moving directly to 'bold actions can be costly' (Pettigrew and Whipp, 1991: 281). It is important to increase the organisation's capacity to implement change before precise interventions are taken. This includes having people committed to change and with leadership capacity in key positions at both executive and operational levels. Recovery and renewal is rarely accomplished by a one-shot fixing-up of a single great issue taken by a 'heroic leader'. These people contribute to creating, embedding and transmitting the desired behavioural attribute

across the whole organisation (Schein 1985). Hence, as some advice, management practices such as conscious team-building, in which a formal selection process is used to identify and put the "best levers" in key, leading positions, should be encouraged at the early stage of the recovery and renewal process.

Fostering an action-oriented culture in the management team is also important to increase an organisation's capacity for change. There was some evidence from our case studies that in the face of adverse performance data managers and professionals tended to respond with indifference or cynicism and/or blame external sources. An action-oriented attitude helps to break the inertia and prompt managers to react to adverse performance data. Hence, there is a need to put some energy into setting the expectation among managers that an action-oriented attitude should prevail when faced with adverse performance feedback (more emphasis on 'action' than on 'justification'). The introduction of a "sense of urgency" among managers on the key targets can also have an effect on prompting managers to react to performance feedback and, thus, enhancing the organisation's capacity for change. Management practices such as regular review meetings to check how well managers are addressing key targets might be instrumental for this purpose.

d) central government intervention to change the leadership of the providers' organisation should be precise and well balanced.

In all cases studied in this research the change of leadership was necessary to trigger the recovery and renewal of the organisations. Paradoxically, too many interventions to change leadership and managers in the organisation have been shown to be detrimental to recovery and renewal. Too much instability in the top management team precludes engagement of professionals with the managerial agenda and makes it difficult to establish an effective relationship with external stakeholders. Hence the succession of CEOs needs to be well managed by policy makers to prevent a high level of instability in the organisation caused by too many changes in a short period of time.

e) Recovering and renewing public service organisations requires the engagement of professionals (clinicians) with the managerial agenda.

Organisations that went through successful recovery and renewal paid particular attention to the engagement of professionals (clinicians) with the managerial agenda. Several measures can contribute to promoting engagement with the managerial agenda. A promising one would be to foster a climate of openness and truthfulness among managers and clinicians. Constant and open communication between executives and influential clinicians would help this purpose. Another way that helps to engage clinicians into the managerial agenda is to establish and involve them in executive and/or operational boards, where they can actively participate in the decision-making process. Having clinicians in key managerial positions also contributes to establishing a common-ground between managers and clinicians, and to legitimize the renewal agenda among professionals. Finally, where the very existence of the organisation is 'in check', incentives based on this threat also have the effect of bringing about engagement, because they can lead actors to believe that important values (*e.g*. the hospital in its current form) will not hold in the future, unless clinicians engage with the proposed changes.

f) Relationship with key external stakeholders matters.

Hospital trusts that pay special attention to the quality of the relationship with key stakeholders, in particular the Commissioners (PCT), are likely to reap benefits of improved performance around key areas of performance, such as waiting lists, re-admissions rates and A&E performance (Mannion *et al,* 2005). Expending energy and time networking externally is advantageous to CEOs and Executives as it improves the quality of the relationship with external stakeholders. It is important thus to encourage and support executives to participate in meetings with executives from other external organisations.

g)An Effective control process is paramount to bring about performance improvement

An effective control process underpinned successful turnaround episodes in the hospitals trusts examined. These trusts displayed a well-orchestrated and effective process to identify critical performance variables, monitor performance against these

variables and respond to performance feedback. Hence, it is worth making an effort to fully understand how the performance is assessed and the activities that have a bearing on a trust's overall performance; investing in an effective information system to monitor the performance against the critical performance area and variables; making sure that information is timely directed to anyone with a need to know it; defining clear lines of performance accountability (who is responsible for what); repeatedly sensing the direction of activity in relation to hoped-for consequences; and exploring the implications of how lines of action need to be readjusted and who will be responsible for each action;

h) Controlling finance is an essential part of the financial recovery process.

Controlling the finances was well executed when the trusts made sense of the cost and income of their activities; elaborated realistic financial planning and effectively controlled the execution of the finances. In the "payment by results" regime, there is need to pay special attention to the accurate coding of the services and activities in order to make sense of the potential income of the activities. Management practices such as bottom-up budget setting also help to make sense of the costs and to formulate a realistic financial plan. There is also a need to invest in a proper accounting system and to make an effort to ensure that deviance is detected in a timely fashion and that actions are taken to respond to it.

i) Streamlining services delivery process in key performance areas is important for optimizing the use of resources and securing gain of productivity and efficiency.

The performance of the hospital trusts is highly dependent on how well they manage the delivery of the key services, such as Accident and Emergency, in-patient waiting lists, out-patients. The provision of a particular service typically involves a wide range of professionals and departments. Effectively coordinating the interdependency of tasks and resources along the pathway of the service delivery can reap benefits of improved performance in these areas. Restructuring the organisation by key areas of service delivery (say medicine, A&E, etc), which put together all relevant tasks under the same structure of command, is advantageous for improving the coordination of the dependencies of tasks and resources along the service delivery pathway. Small procedures, such as problem-solving, inclusive meetings with

participants from all specialties/departments involved in a particular service delivery process, also contributes to improving the coordination of the services.

j) The ability to learn from trial and error in the operation of particular tasks is paramount for developing, adapting and perfecting operating routines involved in the delivery of the services.

Organisations that went through successful recovery and renewal have sought to perfect operating routines of key service delivery areas by implementing mechanisms to learn from trial and error in the execution of particular tasks. As mentioned above, the improvement of the operating routines of particular tasks in important areas such as A&E is likely to reap rewards of improved performance in this area. There is thus a need to invest effort to create mechanisms that facilitate the accumulation of experience, the articulation of knowledge and knowledge codification processes. This can be done by encouraging the use of controlled experiments, creating inclusive groups/board to discuss, review, assess and codify the results of innovative process/services/interventions , in other words, figuring out what works and what does not.

k) Well developed environmental scanning activities underpin an organisation's ability to sense "in what" and "how to" operate in order to satisfy the requisite performance expected by key stakeholders.

The successful case of recovery and renewal was one in which the organisation made a considerable effort to generate and use environmental information. This capability makes the organisation more attentive to the demands and needs of key stakeholders and also to the opportunities and threats in the environment that could have a bearing on its performance. Thus, to successfully recover and renew public service organisations it is essential to invest in management practices that promote the generation and use of environmental information in the decision-making process of the organisation. Practices such as "scenario construction", the increased use of benchmarking, the creation of 'stakeholders (e.g. community, business etc)' advisory groups help to feed the decision-making process of the organisation with valuable information from the environment.

l) The performance effect of a capability increases with the presence of others. Partial implementation of a full set of capabilities yields no return, or might even be detrimental to performance.

Having an ability to, say, perform management functions (functional capabilities) on its own yields insignificant or lower returns on an organisation's performance than if developed together with the ability to change and adapt to a changing environment (organisational/cultural capabilities), and/or with the presence of intangible assets that confer on the organisation a positional advantage (positional capabilities); and vice versa. Hence, managerial interventions aimed at developing some of the above mentioned capabilities should consider that their impact on the trust's performance depends on the existence/development of other complementary capabilities.

9.4 – Further contributions of this research

We believe that the findings presented above represent important contributions to the so far under-explored field of recovery and renewal in public sector organisations. This research has also made some methodological and empirical contributions to the literature, as well as to the debate in the field of organisational capability in general.

9.4.1 - Methodological Contributions.

In one of the most influential and pioneering reviews of empirical studies on organisational recovery or turnaround which have been accumulated since the first studies were published (mid 70's), Hoffman (1989) remarked that we know little about the process of recovery in organisations. He concluded his article by claiming that "research investigating the process by which turnarounds are implemented is sorely needed" and that this requires in-depth historical case studies. However, despite Hoffman's plea (1989), the longitudinal in-depth case study is far from becoming a norm in empirical studies on recovery in organisations. Another comprehensive review of empirical studies on the recovery of organisations carried out by Pandit (1996), reveals that very few studies use a case-study research design to compare cases of successful and failing turnaround and "disappointingly, only one study employs a rigorous qualitative research design: the comparative case study method as advocated

by Yin (1989)" The longitudinal and comparative case-study research design is a particular strength of this research. Our research design allows us to compare successful with less-successful recovery attempts over time.

A further strength of our methodology is the combination of narrative with processual analysis. In particular, we develop an approach for reducing the complexity of the analysis of the recovery and renewal process. This approach consisted of, firstly, decomposing the process into its key components, each representing a particular challenge to be satisfied, and, secondly, identifying the causal factors (process features and context factors) that explain the outcome of the efforts to satisfy each of the challenges.

The multi-method strategy is also an important strength of this research. The combined quantitative and qualitative methodology afforded a novel approach to the study of recovery and renewal in particular, and to the study of organisations in general. By applying a multi-method to analyse the data this thesis had the advantage of counting on the strength of each method and overcomes most of their limitations if taken separately.

9.4.2 - Empirical contributions

The past ten years have witnessed an increase in governments' initiatives to measure and evaluate the performance of public sector organisations. These initiatives are among the most striking features of the administrative reform movement that has taken place in many countries around the world (see Hood, 1991). Such initiatives have enabled governments to identify organisations whose performance is below some pre-established standards. As a consequence immense governmental efforts have been made to recover the performance of failing organisations. However, as Boyne (2006) points out, such efforts have been made without rigorous empirical evidence and theories on recovery of public sector organisations. Indeed, the vast majority of empirical evidence on recovery and renewal has been drawn from private sector organisations. Only recently have empirical studies on recovery in public sector organisations started to emerge (e.g. Turner *et al*, 2004; Boyne and Meier, 2009).

Although the private and public sector organisations might be similar in some dimensions (Rainey, 1997), the relevance of evidence from literature on the private sector might be limited in at least three main aspects. First, performance in the private sector literature is frequently conceived in terms of profitability indicators or market-share, which does not entirely translate into public sector organisation. Second, private sector organisations face a highly competitive environment, whereas most public organisations still enjoy a monopolist or "quasi-monopolist" status (Jas and Skelcher, 2005). Finally, private sector managers enjoy greater discretion in terms of the scope and nature of actions deemed necessary to recover the organisations, while regulations and general principles limit the repertory of actions available to public managers. As a consequence, there is a paucity and need of empirical evidence on the process of recovery in public sector organisations. Therefore, our research contributes to the literature by providing empirical evidence about the process of recovery and renewal in public sector organisations.

The historical account of the two cases is also an important and original contribution of the thesis. To the best of our knowledge, no such rich and comprehensive historical account of turnaround attempts in public hospitals has been provided in the literature thus far – probably due to the difficulties in get access to the organisations. Indeed, gaining access to these two cases was really very difficult and time consuming, especially for the case of the less-successful turnaround, since after all no one wants to be exposed as a "failing" or "less-successful" case.

This thesis has also offered a rare and rich empirical analysis of the complementarities of capabilities and their association with performance. The question of whether organisational capabilities have an effect on an organisation's performance and is the source of its competitive advantage, has spurred some debate in the literature. However, most of this debate has remained at the abstract, theoretical level, as it is the case of Teece *et al'*s (1997) seminal article on 'Dynamics Capabilities and Strategic Management'. More recently some attempts have been made to investigate empirically the link between organisational/dynamics capabilities and performance (*e.g.* Helfat *et al*, 2007; Pavlou and Sawy, 2005; Kor and Mahoney, 2005). Thus our quantitative analysis of the association between performance and capabilities, as well as the complementarities of capabilities and performance, will certainly contribute to enriching this debate.

9.4.3 – Further theoretical contributions

At a theoretical level, we adopt the concept of "capabilities" to explain the recovery and renewal of organisations. Thus far, research on the recovery of organisations has tended to focus on the content of strategies. No studies have attempted to link recovery with organisational and managerial capabilities. In this research we demonstrated that it is by building capabilities that organisations recover their performance and sustain it in the long run. We defined capabilities as the intangible assets that make up the organisational ability to perform some organisational tasks needed for long term performance. Our research question was posed to provide evidence on what capabilities "failing" organisations need for long term performance and how they can be built and used. By adopting the concept of capabilities we provided a novel way to explain the process by which organisations recover their performance and manage to sustain good performance in the long run.

9.5 – Limitations of the study and avenues for future research

Like most research, this thesis has also its limitations, which, on the other hand, open up challenges and suggest avenues for future research. Regarding the qualitative methods, our analysis was drawn on the basis of only two cases of acute hospital trusts in England: one case of successful turnaround and one case of a less-successful turnaround. Consequently, questions might be raised as to the extent to which the research's findings can be applicable to other contexts or other kinds of public service organisations, such as schools, police departments, local authorities and so on. Considering that our findings are supported by literature on organisational failure, recovery and renewal in both public and private organisations, some generabilizability may be claimed. However, peculiar characteristics of these kinds of organisations, notably in terms of regulatory and performance accountability arrangements, demand that further research into other kinds of public service organisations be conducted before the external validity of the findings to other contexts can be claimed.

As for the quantitative analysis, our statistical model has the same limitation as Milgron and Roberts's empirical analysis of complementarities: it is static, that is it did not capture the dynamic of change in performance which is associated with change in capabilities. Our model is, nevertheless, suggestive about the effect of increasing

capability on performance improvement, and only partially captures the notion of change (i.e. 'doing more of one thing') underlying the definition of complementarities. This limitation was obviously due to the lack of and difficulty in obtaining datasets that reflect changes in both dependent and independent variables. Such a dynamic model would require at least two datasets (containing both dependent (performance) and independent variables (capabilities)) taken in different point in time; an option which proved to be operationally unfeasible to be implemented in the timeframe of this research. Hence future research should try to develop models to test the dynamic relation between performance improvement and complementarities in the development of capabilities, and check whether they yield similar results to this research.

As we discussed in Chapter One, the performance of public service organisations is difficult to define and subject to controversy. This research was facilitated by the performance governance system established in England by central government, which provides an overall score to all hospital trusts based on the achievement of key targets and some other performance indicators. To such a performance governance system was added strong pressure from the central government, which included dismissal of CEOs, or even the whole top-management team, as a government response to poor performance. This mixture of targets and external pressure created the Bevan and Hood's (2005) "target and terror" governance system. However, there are several ways by which the performance of public service organisations can be measured. An insightful discussion of the different systems of performance measurement can be found in the recent works by Bevan and Hood (2007), Bevan and Hamblin (2009) and Hood (2007). Further research may show whether other performance governance systems produce similar results to this research.

In this thesis we found that building a "collective leadership" is important in the early stages of the recovery and renewal process, namely, the need to have key people with leadership capacity committed to change in key positions within the organisation. However, we did not consider the contextual and time-dependent nature of the leadership. Osborn *et al* (2002) make the point that key leadership dimensions and characteristics may vary according to the context, which in its turn may also change over time. They go on to suggest different characteristics and behaviour of leadership in four contexts: stability; crisis; dynamic equilibrium; and the edge of chaos. Some, if now all, of these contexts can possibly happen along a complete recovery and renewal

trajectory. Hence, further research may need to isolate the specific type and characteristic of leadership which is demanded for key stages of the turnaround and renewal trajectory.

Although we have addressed the effect of Human Resources Management (HRM) capability while analysing the creation of collective leadership and the effective managerial-clinical relationship, we have not addressed it directly as another functional capability that plays an important role in the recovery and renewal process. HRM has an important function to play in the selection of leaders and managers across the organisation and in the development of educational programmes deemed necessary to develop management skills for clinicians holding managerial positions. Our analysis of the creation of collective leadership and engagement of clinicians into the managerial agenda is a proxy analysis of the effect of HRM capability. Further research can analyse more directly the role of HRM capability in the recovery and renewal process.

The recovery and renewal of organisations is a complex and multi-faceted phenomenon. As Machiavelli had already observed hundreds of years ago "*there is nothing more difficult to carry out, nor more doubtful of success, nor more dangerous to handle, than to initiate a new order of things*" ('The Prince', Chapter VI). Despite being old, this statement remains valid. Throughout this thesis we sought to shed light on this complex phenomenon, particularly by identifying several challenges of the recovery and renewal process and how they could be satisfied by the development of some key capabilities. However, this thesis is still a limited and modest contribution to the field and practice of management of organisations, in general, and public service organisations in particular. More research needs to be done in the field of the performance of public service organisations, which have been under unprecedented pressure to renew in order to offer better and cheaper services to the citizens.

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APPENDIX A

Calculation of composite reliability measure using AMOS 16.0

questions		constructs	Standardized regression weights (a)	Square of the standardized regression weights b=a^2	indicator measurement error c= (1-b)	composite reliability d=(Σa)^2/((Σa)^2+Σc)
Q11	<---	Action	0.774	0.599076	0.400924	0.76
Q7	<---	Action	0.735	0.540225	0.459775	
Q10	<---	Action	0.623	0.388129	0.611871	
Q19	<---	Control	0.763	0.582169	0.417831	0.77
Q20	<---	Control	0.669	0.447561	0.552439	
Q21	<---	Control	0.733	0.537289	0.462711	
Q32	<---	Coord	0.737	0.543169	0.456831	0.81
Q33	<---	Coord	0.793	0.628849	0.371151	
Q34	<---	Coord	0.781	0.609961	0.390039	
Q4	<---	Leader	0.706	0.498436	0.501564	0.71
Q5	<---	Leader	0.777	0.603729	0.396271	
Q49	<---	Learn	0.838	0.702244	0.297756	0.88
Q48	<---	Learn	0.809	0.654481	0.345519	
Q47	<---	Learn	0.712	0.506944	0.493056	
Q46	<---	Learn	0.729	0.531441	0.468559	
Q45	<---	Learn	0.789	0.622521	0.377479	
Q12	<---	mc_rel	0.787	0.619369	0.380631	0.85
Q13	<---	mc_rel	0.809	0.654481	0.345519	
Q15	<---	mc_rel	0.724	0.524176	0.475824	
Q16	<---	mc_rel	0.729	0.531441	0.468559	
Q43	<---	Scan	0.765	0.585225	0.414775	0.86
Q42	<---	Scan	0.772	0.595984	0.404016	
Q41	<---	Scan	0.804	0.646416	0.353584	
Q40	<---	Scan	0.837	0.700569	0.299431	
Q39	<---	Scan	0.751	0.564001	0.435999	
Q38	<---	Scan	0.738	0.544644	0.455356	

APPENDIX B

Calculation of discriminant validity

Question		Construct	Standardized regression weight (loadings) (a)	Square of loadings b= a^2	Indicator measurement error c=1-b	AVE d=Σb/(Σb + Σc)	√AVE √d
Q11	<---	Action	0.774	0.599076	0.400924	0.509143	0.714
Q7	<---	Action	0.735	0.540225	0.459775		
Q10	<---	Action	0.623	0.388129	0.611871		
Q19	<---	Conrol	0.763	0.582169	0.417831	0.52234	0.723
Q20	<---	Conrol	0.669	0.447561	0.552439		
Q21	<---	Conrol	0.733	0.537289	0.462711		
Q32	<---	Coord	0.737	0.543169	0.456831	0.593993	0.771
Q33	<---	Coord	0.793	0.628849	0.371151		
Q34	<---	Coord	0.781	0.609961	0.390039		
Q4	<---	Leader	0.706	0.498436	0.501564	0.551083	0.742
Q5	<---	Leader	0.777	0.603729	0.396271		
Q49	<---	Learn	0.838	0.702244	0.297756	0.603526	0.777
Q48	<---	Learn	0.809	0.654481	0.345519		
Q47	<---	Learn	0.712	0.506944	0.493056		
Q46	<---	Learn	0.729	0.531441	0.468559		
Q45	<---	Learn	0.789	0.622521	0.377479		
Q12	<---	mc_rel	0.787	0.619369	0.380631	0.582367	0.763
Q13	<---	mc_rel	0.809	0.654481	0.345519		
Q15	<---	mc_rel	0.724	0.524176	0.475824		
Q16	<---	mc_rel	0.729	0.531441	0.468559		
Q43	<---	Sensing	0.765	0.585225	0.414775	0.60614	0.779
Q42	<---	Sensing	0.772	0.595984	0.404016	0.647656	
Q41	<---	Sensing	0.804	0.646416	0.353584	0.636995	
Q40	<---	Sensing	0.837	0.700569	0.299431	0.603071	
Q39	<---	Sensing	0.751	0.564001	0.435999	0.554323	
Q38	<---	Sensing	0.738	0.544644	0.455356	0.544644	

Correlations between different constructs

			Estimate				Estimate
Learn	<-->	Action	0.499	Sensing	<-->	mc_rel	0.501
Learn	<-->	Scan	0.593	Sensing	<-->	Coord	0.552
Learn	<-->	mc_rel	0.477	Sensing	<-->	Conrol	0.499
Learn	<-->	Coord	0.726	Sensing	<-->	Leader	0.563
Learn	<-->	Leader	0.467	mc_rel	<-->	Coord	0.496
Learn	<-->	Conrol	0.599	mc_rel	<-->	Conrol	0.604
Action	<-->	Sensing	0.612	mc_rel	<-->	Leader	0.686
Action	<-->	mc_rel	0.638	Coord	<-->	Conrol	0.564
Action	<-->	Coord	0.538	Coord	<-->	Leader	0.5
Action	<-->	Conrol	0.685	Conrol	<-->	Leader	0.59
Action	<-->	Leader	0.68				

APPENDIX C

LETTER TO POTENTIAL PARTICIPANTS OF THE SURVEY

You are being invited to take part in a research study about the **performance improvement of hospital trusts in England.** This research is being conducted under the direct supervision and support of **Professor Andrew Pettigrew** at the School of Management of the University of Bath. The questionnaire is already available on-line at http://www.survey.bris.ac.uk/bathreg/capabilities **. An e-mail containing this link to the on-line questionnaire will also be sent to you in the next few days.**

The purpose of this research is to understand the managerial and organisational processes associated with sustained good performance of hospital trusts. To date attempts of managers to improve and sustain good performance have been conducted without robust evidence. The results of this survey will help to fill this gap and will provide a valuable support for the performance management of hospital trusts.

This survey is directed towards the **CEO and four executive directors** of each trust (including the finance directors, medical directors and the directors responsible for operations or performance management). **Your participation in this survey is very important.**

Please fill out the questionnaire as soon as possible. The questionnaire comprises questions on nine topics, which should take **only 10 minutes or less** to complete. **All data collected in this survey will be held anonymously and securely**. **No individual or organisation will be identified in the analysis**. Data will be treated only on an aggregate basis. The research has received Ethical Approval from **NHS Research Ethics Committee.**

Below are the comments of some people with whom we had the opportunity to discuss the content and importance of this survey.

> *"I strongly support this study and encourage you to respond. The evidence base is surprisingly sparse and we need to build knowledge on this crucial topic."*
> **(Helen Bevan -** Director of Service Transformation, NHS Institute for Innovation and Improvement)
>
> *"This is an important piece of research which fills a key gap in current knowledge and will be directly useful to the NHS. "*
> (**Nigel Edwards** – Policy Director of The NHS Confederation)
>
> **"***I have worked with the University of Bath on this crucial piece of research to help the NHS understand what makes the difference in our organisations. Thanks for doing this. It won't take long to complete."*
> (**Peter Dawn** – CEO of the University Hospitals Bristol NHS Foundation Trust.)

A short report summarizing the results of this survey will be offered to you after the completion of the questionnaire. If you have any question or concerns about the survey, please feel free to contact me at s.n.seabra@bath.ac.uk.

Thanks for your help.
Sincerely,

Sergio Seabra
PhD Researcher

APPENDIX D

STATA'S "DO FILE" FOR ANALYSIS OF COMPLEMENTARITIES

```
insheet using "C:\Users\Sergio\Documents\Dados Survey\capabilities.csv
recode q19 1/2=0 3/5=1
recode q20 1/2=0 3/5=1
recode q21 1/2=0 3/5=1
recode q32 1/2=0 3/5=1
recode q33 1/2=0 3/5=1
recode q34 1/2=0 3/5=1
recode q38 1/2=0 3/5=1
recode q39 1/2=0 3/5=1
recode q40 1/2=0 3/5=1
recode q41 1/2=0 3/5=1
recode q42 1/2=0 3/5=1
recode q43 1/2=0 3/5=1
recode q45 1/2=0 3/5=1
recode q46 1/2=0 3/5=1
recode q47 1/2=0 3/5=1
recode q48 1/2=0 3/5=1
recode q49 1/2=0 3/5=1
recode q4 1/2=0 3/5=1
recode q5 1/2=0 3/5=1
recode q7 1/2=0 3/5=1
recode q8 1/2=0 3/5=1
recode q9 1/2=0 3/5=1
recode q10 1/2=0 3/5=1
recode q11 1/2=0 3/5=1
recode q12 1/2=0 3/5=1
recode q13 1/2=0 3/5=1
recode q15 1/2=0 3/5=1
recode q16 1/2=0 3/5=1
recode q18_a 1/2=0 3/5=1
recode q18_b 1/2=0 3/5=1
recode q18_c 1/2=0 3/5=1
recode q18_d 1/2=0 3/5=1
recode q18_e 1/2=0 3/5=1
recode q18_f 1/2=0 3/5=1
recode q18_g 1/2=0 3/5=1
generate control = q19 + q20 + q21
recode control 0/2=0 3=1
generate coord = q32 + q33 + q34
recode coord 0/2=0 3=1
generate scan = q38 + q39 + q40 + q41 + q42 + q43
recode scan 0/3=0 4/6=1
generate learn = q45 + q46 + q47 + q48 + q49
recode learn 0/2=0 3/5=1
generate col_leader = q4 + q5
recode col_leader 0/1=0 2=1
generate act_cult = q7 + q10 + q11
recode act_cult 0/2=0 3=1
```

```
generate mc_relat = q12 + q13 + q15 + q16
recode mc_relat 0/2=0 3/4=1
generate ext_relat = q18_a + q18_b + q18_c + q18_d + q18_e + q18_f + q18_g
recode ext_relat 0/4=0 5/7=1
generate processes = control + coord + scan + learn
recode processes 0/3=0 4=1
generate incontext = col_leader + mc_relat + act_cult
recode incontext 0/2=0 3=1
generate outcontext = ext_relat
generate system1 = processes + incontext + outcontext
recode system1 0/2=0 3=1
generate system2 = processes + incontext
recode system2 0/1=0 2=1
generate system3 = processes + outcontext
recode system3 0/1=0 2=1
generate system4 = incontext + outcontext
recode system4 0/1=0 2=1
generate category = q2
recode category 4=6
recode category 7=6
tabulate category, generate (role)
label variable role1 “CEO”
label variable role2 “medical_director”
label variable role3 “finance_director”
label variable role4 “director_of_Operations”
svyset trust [pweight=respwgt]
svy: oprobit quali08 system1 system2 system3 system4 size quali07 m_factor role1
role2 role3
test role1 role2 role3
svy: oprobit quali08 system1 system2 system3 system4 control coord scan learn
col_leader act_cult mc_relat ext_relat size quali07 m_factor role1 role2 role3
test role1 role2 role3
svy: oprobit quali08 control coord scan learn col_leader act_cult mc_relat ext_relat size
quali07 m_factor role1 role2 role3
test role1 role2 role3
```

APPENDIX E

Survey Questionnaire

A. Please write the name of your organization.

B. Please tick (x) the box which most closely describes **your position** in the organization.

CEO [ ] Medical Director [ ] Financial Director [ ] Director of Operations (or equivalent) [ ]

Other [specify]

C. How long have you been working in this Trust?

Less than a year [ ] Between one and three years [ ] Four years or ore [ ]

Collective Leadership

1. Please highlight in bold the extent to which the following statement is true for your organisation**. (highlight in bold the number that corresponds to your answer)**

		Emphasis				
		None	*Little*	*Moderate*	*Much*	*Great*
		1	***2***	***3***	***4***	***5***
1.1	We select clinical staff for key, senior operational positions (e.g. clinical directors) based on their proven ability to lead and manage.	--1------2-------3--------4------5---				
1.2	We have our management and clinical leaders posts across the Trust filled by people with proven leadership capability.	--1------2-------3--------4------5---				

Action-Oriented Behaviour

2. To what extent do managers in your organisation demonstrate any of the following features**?**

		Emphasis				
		None	*Little*	*Moderate*	*Much*	*Great*
		1	***2***	***3***	***4***	***5***
2.1	A willingness to explore new strategies or organisational practices.	--1------2-------3--------4------5---				
2.2	The view that they can control the organisation's destiny.	--1------2-------3--------4------5---				
2.3	Senior managers are committed, positive and with a bias for action	--1------2-------3--------4------5---				

Managerial-clinician relationships

3. To what extent does your organization display any of the following features?

		Emphasis				
		None	*Little*	*Moderate*	*Much*	*Great*
		1	***2***	***3***	***4***	***5***
3.1	Overall, clinicians are engaged with the managerial/change agenda	--1-----2-------3--------4------5---				
3.2	We have established open and trusting communication with key clinicians	--1-----2-------3--------4------5---				
3.3	Key clinicians are involved in the strategic decision making process (e.g. 3-5 year plans for the trust)	--1-----2-------3--------4------5---				
3.4	Lead clinicians participate, together with managers, in the operational and strategic decision making process of their particular division/directorate.	--1------2-------3--------4------5---				

External networking

5. How would you describe <u>the quality</u> of the relationship of the Trust with the following people?

		Emphasis				
		very poor	*poor*	*Moderate*	*good*	*excellent*
18a	Commissioners	-1	2	3	4	5
18b	Senior managers of the Strategic Health Authority	-1	2	3	4	5
18c	Senior managers of the Department of Health	-1	2	3	4	5
18d	Senior managers of other hospital trusts in the region	-1	2	3	4	5
18e	Members of the business community	-1	2	3	4	5
18f	Members of the local community	-1	2	3	4	5
18g	Patient groups/representatives	-1	2	3	4	5

Performance control capability

6. To what extent are the following statements true for your organization?

		Emphasis				
		None	*Little*	*Moderate*	*Much*	*Great*
19	We are effective at setting goals and targets regarding the performance of key tasks.	--1	2	3	4	5---
20	We have an effective information system that enables managers to judge their progress towards meeting goals and targets.	--1	2	3	4	5---
21	We ensure that managers receive feedback on whether they are meeting the expected goals and targets.	--1	2	3	4	5---

Coordination capability

8. To what extent are the following statements true for your organization?

		Emphasis				
		None	*Little*	*Moderate*	*Much*	*Great*
32	We ensure that the activities involved in the key service delivery processes (e.g. A&E) fit together very well.	--1	2	3	4	5---
33	We ensure that the output of a unit's work is synchronized with the work of the others in the same patient pathway.	--1	2	3	4	5---
34	We ensure that the output of a unit's work is of a form useful to others when needed (the right thing at the right time)	--1	2	3	4	5---

Scanning Capability

9. To what extent are the following statements true for your organization?

		Emphasis: None Little Moderate Much Great
38	We frequently scan the environment to identify new opportunities or need for changes	--1------2-------3--------4------5---
39	We are quick to discuss changes in our stakeholders' services preferences or priorities	--1------2-------3--------4------5---
40	We periodically review the likely effect of changes in our environment (e.g. competitors, customers, supplies, commissioners) on customers	--1------2-------3--------4------5---
41	We often review our services delivery efforts to ensure that they are in line with what key stakeholders want	--1-- ---2-------3--------4------5---
42	We make sure that our decision-making process takes into account information on the external environment	--1------2-------3--------4------5---
43	We are quick to respond to significant changes in our environment	--1------2-------3--------4------5---

Learning Capability

10. To what extent are the following statements true for your organization?

		Emphasis: None Little Moderate Much Great
45	We have adequate routines for storing knowledge obtained from experiments on implementing new ideas (knowledge accumulation)	--1--------2-------3--------4------5---
46	We have adequate routines for analyzing the information and knowledge obtained (identifying what works and what doesn't).	--1--------2-------3--------4------5---
47	We can successfully transform the knowledge obtained from direct experience into written tools (e.g. manuals, blueprints, spreadsheets, decision support systems, software)	--1--------2-------3--------4------5---
48	We have effective routines for sharing and transferring the acquired knowledge within the organization.	--1--------2-------3--------4------5---
49	We are effective in transforming existing information into new knowledge.	--1--------2-------3--------4------5---

Thank You…

Please tick the box below if you would like to receive a short report summarizing the results of this survey.

I want to receive a short report summarizing the results of this survey [ ]

APPENDIX F

INTERVIEW SCHEDULE

Research project:	**Building capabilities to recover and renew public service organisations.**
Respondent's name:	
Position:	
Organisation:	
Interviewer:	
Date of Interview	
Interview recorded?	
Data file name:	
Data storage location :	

Interview topic guide

Theme	Questions
A. Wider context	What were the contextual issues shaping the organisation in 2001/2002? e.g. major policies decisions from the Whitehall, the rise of the performance governance system and how it affected the organisation. What were the drives for changes from outside? e.g. the influence of the HAS. What did they try to achieve? Could you identify other sources of pressures and influence from other organisations and other external stakeholders? What were the key episodes in the evolution of the NHS performance governance system?
B. Organisational context	What were the characteristics and history of the trust in 2001/2002, when the first performance date was published? What were the key deficits in organisational capability and/or key organisational or managerial features that contributed to the poor results in 2001/2002? How did the organisation look like at that period, in terms of key dimensions, such as financial terms, clinical capacity, culture, managerial competence, systems, governance, board, structure, etc?

C. Change process and Strategy elaboration	Could you describe how the trust addressed the problem of poor performance received in 2001/2002?. Potential prompt questions: What were the strategies to deal with the situation? What were the envisaged changes? What were the barriers to implementation changes? What actually were delivered? What were the key success and key setbacks? What were the targets and performance issues over that period of time? How was the strategy/plan elaborated? Who participate? How were the priorities identified? Was there agreement about these priorities? Who disagree? How were the terms/priorities of the strategy negotiated with key external and internal stakeholders? What in your opinion should have been included that was not considered? Could you describe the critical episodes in the process of diagnosing the situation, elaboration and implementation of the strategies to bring about performance improvement?
D. Managerial and organisational capabilities	What organisational functions have been crucial to the performance of the organisation? Could you describe how did the organisation perform these functions and how did the practices used to perform these functions change over time? Potential prompt questions: Could you please tell us in detail the extent to which the organisation's ability (or lack of) to perform the following organisational tasks has been a crucial variable in the attempts to improve the performance of the organisation? And how the organisational practices used to perform these tasks developed and were exploited over time? For instances: - To control the critical performance variables; - To get employee/managers accountable for their Performance; - To acquire and appreciate and use information on the external environment and internal functioning of the organisation that has a bearing on future organisation performance? - To get closer to costumer and to understand and respond to their needs and demands. - To Coordination of work across boundaries between subunits, functions or specialities - To learn from past failures or success. .

APPENDIX G

PARTICIPANT INFORMATION SHEET
Building capabilities to recover and renew
public service organisations.
Principal investigator: Mr. Sergio Seabra
Supervisor: Professor Andrew Pettigrew

Introduction

You are being invited to take part in a research study. This research is being conducted as part of a PhD in Management. Before you decide whether to take part you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Purpose of the research.

The purpose of this research is to investigate the process by which an organization that has been given an adverse performance score manages to improve its performance and sustain it in the long run. I am particularly interested in the organisational and managerial practices that need to be developed in order to bring about a sustained performance improvement in the organisation.

This research will employ both qualitative and quantitative methods. Regarding the qualitative aspect, I will be conducting in-depth interviews in two hospital Trusts in England. The purpose of these interviews is to obtain an historical account of the managerial and organisational practices that led to the performance improvement of the organisation. As for the quantitative part of the research, we will send a survey questionnaire to the CEO of all acute hospital Trusts in England. The questionnaires will be used to obtain data about the extent to which organisations have used some organisational and managerial practices in two period of time. Advanced statistical analysis will then be carried out to measure the extent to which the use of these practices over time is associated with variation in the performance of the organisation.

Your participation

You have been chosen for interview due to your knowledge of the transformation process taking place over the past 5 years, or due to your involvement in, or knowledge of, some managerial or organisational practices that have been used/developed in order to bring about performance improvement of the Trust. Your participation is completely voluntary – you do not have to participate in the study if you don't wish. If you agree to participate I will ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This would not affect your situation in the organisation.

Interview Procedure.

We expect to interview around 20-25 people in each Trust, including top and middle level managers, and other professional staff. In general, the interview questions are organised around four themes, as described in the interview schedule, namely: the context (the wider context of NHS and internal context of the trust); key managerial/organisational practices, whose absence was diagnosed as key factors that contributed to the organisation's poor results in 2001 and 2002; the change process; and the use of key managerial/organisational practices over time. Each interview is expected to last between 60 and 80 minutes, depending on your knowledge and participation in the transformation process, or in the use of some key managerial and organisational practices. You are expected to be interviewed only once. However, if issues arise that we wish to follow up at a later date, we may seek your permission to interview you again. All interviews are planned to take place in your organization, in your office or other place that is most convenient for you. If you agree to be interviewed, I will ask for your permission to tape record the interview, so that we can be assured the data analysis will be based on a comprehensive and accurate account of the interview.

Use and publication of the results

The main outcome of this research is a PhD Thesis. It is also expected that part of the thesis will be published in academic management journals and/or in the form of an academic book. It is also part of the creation of academic knowledge, to present and discuss the outcome of the research in academic seminars and conferences. You will be advised where to access the full thesis and published or conference papers. You will also be offered the opportunity to receive a summary of the results relevant to your own organization.

Payment and benefits

There is no organizational or individual payment for participation in the research study.

Confidentiality and risks

I will follow ethical and legal practice and all information will be handled in confidence and treated anonymously. All published and unpublished reports will disguise the identities of the respondents. This means that any quotation from the participants' response used in all reports and papers will be anonymous. Data collected will be held securely and confidentially at the University of Bath.

Who reviewed the study?

This study has been reviewed in relation to its scientific quality and ethical aspects. The scientific quality of this research was attested by a panel of Professors of the University of Bath's School of Management. Regarding the ethical issues related to this research, this study was given a favourable ethical opinion for conduct by the Berkshire Research Ethics Committee.

Concerns about the study

Any concerns about the research can be addressed by contacting the principal investigator, Mr. Sergio Seabra, on (01225) 425307 or at s.n.seabra@bath.ac.uk, in the first instance. If there are any issues that remain unresolved, these can be followed up with the Dean of the School of Management, Professor Andrew Pettigrew, on (01225) 383052 or a.m.pettigrew@bath.ac.uk. Professor Pettigrew is the academic supervisor of my PhD.

Further information or queries

If you have any further questions, you can contact the principal investigator, Mr. Sergio Seabra, on (01225) 425307 or at s.n.seabra@bath.ac.uk, who will do his best to answer your questions. If you would like to participate in the study, but have special needs that will need to be accommodated, please let us know so that we can make the necessary arrangements.

APPENDIX H

CONSENT FORM

Title of Project: Building capabilities to recover and renew public service organisations.

Name of Researcher: Mr. Sergio Seabra

Please initial each box

I confirm that I have read and understand the information sheet for the above study (version 2.0 dated 27/08/2007) and have had the opportunity to consider the information, and have had these answered satisfactorily.	
I understand that my participation in this study is entirely voluntary and that I am free to withdraw at any time without giving any reason.	
I agree to take part in the above study.	
I agree to the tape-recording of the interview between myself and the Researcher.	
I agree to the use of anonymous quotation from my interview	

Name of person	Date	Signature
Name of Researcher	Date	Signature

APPENDIX I

Performance of Acute Hospital Trusts in the 2007 Annual Health Check

Trust name	score	score
Aintree University Hospitals NHS Foundation Trust,	Fair	2
Airedale NHS Trust,	Good	3
Ashford and St Peter's Hospitals NHS Trust,	Good	3
Barking, Havering and Redbridge Hospitals NHS Trust,	Fair	2
Barnet and Chase Farm Hospitals NHS Trust,	Good	3
Barnsley Hospital NHS Foundation Trust,	Excellent	4
Barts and The London NHS Trust,	Fair	2
Basildon and Thurrock University Hospitals NHS Foundation Trust,	Excellent	4
Basingstoke and North Hampshire NHS Foundation Trust,	Excellent	4
Bedford Hospital NHS Trust,	Weak	1
Birmingham Children's Hospital NHS Foundation Trust,	Fair	2
Birmingham Women's NHS Foundation Trust,	Good	3
Blackpool, Fylde and Wyre Hospitals NHS Foundation Trust,	Fair	2
Bolton Hospitals NHS Trust,	Good	3
Brighton and Sussex University Hospitals NHS Trust,	Excellent	4
Burton Hospitals NHS Trust,	Excellent	4
Calderdale and Huddersfield NHS Foundation Trust,	Excellent	4
Central Manchester and Manchester Children's University Hospitals NHS Trust,	Fair	2
Chelsea and Westminster Hospital NHS Foundation Trust,	Good	3
Christie Hospital NHS Foundation Trust,	Excellent	4
City Hospitals Sunderland NHS Foundation Trust,	Excellent	4
Clatterbridge Centre For Oncology NHS Foundation Trust,	Excellent	4
Derby Hospitals NHS Foundation Trust,	Good	3
Doncaster and Bassetlaw Hospitals NHS Foundation Trust,	Good	3
Dorset County Hospital NHS Foundation Trust,	Excellent	4
Dudley Group Of Hospitals NHS Trust,	Good	3
Ealing Hospital NHS Trust,	Fair	2
East Cheshire NHS Trust,	Good	3
East Kent Hospitals NHS Trust,	Fair	2
East Lancashire Hospitals NHS Trust,	Excellent	4
East Sussex Hospitals NHS Trust,	Fair	2
	Excellent	4
Gateshead Health NHS Foundation Trust,	Good	3
George Eliot Hospital NHS Trust,	Good	3
Gloucestershire Hospitals NHS Foundation Trust,	Good	3
Great Ormond Street Hospital For Children NHS Trust,	Good	3
Guy's and St Thomas' NHS Foundation Trust,	Good	3
Harrogate and District NHS Foundation Trust,	Excellent	4
Heart Of England NHS Foundation Trust,	Good	3

Heatherwood and Wexham Park Hospitals NHS Foundation Trust,	Good	3
Hereford Hospitals NHS Trust,	Good	3
Hinchingbrooke Health Care NHS Trust,	Good	3
Homerton University Hospital NHS Foundation Trust,	Excellent	4
Hull and East Yorkshire Hospitals NHS Trust,	Good	3
Imperial College Healthcare NHS Trust,	Good	3
Ipswich Hospital NHS Trust,	Good	3
Kettering General Hospital NHS Trust,	Excellent	4
King's College Hospital NHS Foundation Trust,	Fair	2
Kingston Hospital NHS Trust,	Good	3
Luton and Dunstable Hospital NHS Foundation Trust,	Fair	2
Medway NHS Foundation Trust,	Fair	2
Mid Cheshire Hospitals NHS Foundation Trust,	Good	3
Mid Essex Hospital Services NHS Trust,	Excellent	4
Mid Staffordshire NHS Foundation Trust,	Good	3
Moorfields Eye Hospital NHS Foundation Trust,	Fair	2
Norfolk and Norwich University Hospitals NHS Foundation Trust,	Good	3
North Bristol NHS Trust,	Fair	2
North Cumbria University Hospitals NHS Trust,	Excellent	4
North Middlesex University Hospital NHS Trust,	Good	3
North West London Hospitals NHS Trust,	Fair	2
Northampton General Hospital NHS Trust,	Good	3
Northern Lincolnshire and Goole Hospitals NHS Foundation Trust,	Good	3
Northumbria Healthcare NHS Foundation Trust,	Good	3
Nottingham University Hospitals NHS Trust,	Fair	2
Nuffield Orthopaedic Centre NHS Trust,	Fair	2
Pennine Acute Hospitals NHS Trust,	Good	3
Peterborough and Stamford Hospitals NHS Foundation Trust,	Weak	1
Plymouth Hospitals NHS Trust,	Fair	2
Poole Hospital NHS Foundation Trust,	Excellent	4
Queen Victoria Hospital NHS Foundation Trust,	Excellent	4
Royal Brompton and Harefield NHS Trust,	Excellent	4
Royal Devon and Exeter NHS Foundation Trust,	Excellent	4
Royal Free Hampstead NHS Trust,	Excellent	4
Royal Liverpool Childrens NHS Trust,	Excellent	4
Royal National Hospital For Rheumatic Diseases NHS Foundation Trust,	Fair	2
Royal National Orthopaedic Hospital NHS Trust,	Weak	1
Royal United Hospital Bath NHS Trust,	Good	3
Salford Royal NHS Foundation Trust,	Excellent	4
Salisbury NHS Foundation Trust,	Good	3
Sandwell and West Birmingham Hospitals NHS Trust,	Good	3

Sheffield Children's NHS Foundation Trust,	Excellent	4
Shrewsbury and Telford Hospital NHS Trust,	Good	3
South Devon Healthcare NHS Foundation Trust,	Good	3
South Tees Hospitals NHS Trust,	Good	3
South Warwickshire General Hospitals NHS Trust,	Excellent	4
Southampton University Hospitals NHS Trust,	Good	3
Southend University Hospital NHS Foundation Trust,	Excellent	4
Southport and Ormskirk Hospital NHS Trust,	Excellent	4
St George's Healthcare NHS Trust,	Good	3
St Helens and Knowsley Hospitals NHS Trust,	Excellent	4
Stockport NHS Foundation Trust,	Excellent	4
Swindon and Marlborough NHS Trust,	Good	3
Tameside Hospital NHS Foundation Trust,	Good	3
Taunton and Somerset NHS Foundation Trust,	Good	3
The Hillingdon Hospital NHS Trust,	Good	3
The Lewisham Hospital NHS Trust,	Fair	2
The Princess Alexandra Hospital NHS Trust,	Good	3
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust,	Good	3
The Royal Orthopaedic Hospital NHS Foundation Trust,	Good	3
The Royal Wolverhampton Hospitals NHS Trust,	Excellent	4
The Whittington Hospital NHS Trust,	Good	3
University Hospitals Of Bristol NHS Foundation Trust,	Good	3
United Lincolnshire Hospitals NHS Trust,	Good	3
University College London Hospitals NHS Foundation Trust,	Good	3
University Hospital Birmingham NHS Foundation Trust,	Good	3
University Hospital Of North Staffordshire NHS Trust,	Good	3
University Hospital Of South Manchester NHS Foundation Trust,	Excellent	4
Walsall Hospitals NHS Trust,	Good	3
Walton Centre For Neurology and Neurosurgery NHS Trust,	Excellent	4
West Hertfordshire Hospitals NHS Trust,	Fair	2
West Middlesex University Hospital NHS Trust,	Fair	2
Weston Area Health NHS Trust,	Good	3
Whipps Cross University Hospital NHS Trust,	Good	3
Winchester and Eastleigh Healthcare NHS Trust,	Good	3
Wrightington, Wigan and Leigh NHS Trust,	Good	3
Yeovil District Hospital NHS Foundation Trust,	Excellent	4
York Hospitals NHS Foundation Trust,	Excellent	4
Newham University Hospital NHS Trust,	Fair	2
North Cheshire Hospitals NHS Trust,	Good	3
Papworth Hospital NHS Foundation Trust,	Good	3
Queen Mary's Sidcup NHS Trust,	Fair	2
Robert Jones and Agnes Hunt Orthopaedic and District Hospital NHS Trust,	Fair	2

The Newcastle Upon Tyne Hospitals NHS Foundation Trust,	Excellent	4
The Queen Elizabeth Hospital King's Lynn NHS Trust,	Good	3
Worcestershire Acute Hospitals NHS Trust,	Good	3
Worthing and Southlands Hospitals NHS Trust,	Fair	2
Bradford Teaching Hospitals NHS Foundation Trust,	Good	3
Bromley Hospitals NHS Trust,	Fair	2
Buckinghamshire Hospitals NHS Trust,	Fair	2
Cambridge University Hospitals NHS Foundation Trust,	Excellent	4
Chesterfield Royal Hospital NHS Foundation Trust,	Excellent	4
Countess Of Chester Hospital NHS Foundation Trust,	Good	3
County Durham and Darlington NHS Foundation Trust,	Excellent	4
Dartford and Gravesham NHS Trust,	Excellent	4
East and North Hertfordshire NHS Trust,	Fair	2
Epsom and St Helier University Hospitals NHS Trust,	Good	3
Frimley Park Hospital NHS Foundation Trust,	Excellent	4
James Paget University Hospitals NHS Foundation Trust,	Excellent	4
Lancashire Teaching Hospitals NHS Foundation Trust,	Good	3
Leeds Teaching Hospitals NHS Trust,	Weak	1
	Good	3
Maidstone and Tunbridge Wells NHS Trust,	Weak	1
Mayday Healthcare NHS Trust,	Fair	2
Mid Yorkshire Hospitals NHS Trust,	Good	3
Milton Keynes Hospital NHS Foundation Trust,	Good	3
North Tees and Hartlepool NHS Foundation Trust,	Good	3
Northern Devon Healthcare NHS Trust,	Good	3
Oxford Radcliffe Hospitals NHS Trust,	Excellent	4
Portsmouth Hospitals NHS Trust,	Excellent	4
Queen Elizabeth Hospital NHS Trust,	Good	3
Royal Berkshire NHS Foundation Trust,	Good	3
Royal Cornwall Hospitals NHS Trust,	Weak	1
Royal Liverpool and Broadgreen University Hospitals NHS Trust,	Good	3
Royal Surrey County Hospital NHS Trust,	Excellent	4
Royal West Sussex NHS Trust,	Good	3
Scarborough and North East Yorkshire Health Care NHS Trust,	Weak	1
Sheffield Teaching Hospitals NHS Foundation Trust,	Excellent	4
Sherwood Forest Hospitals NHS Foundation Trust,	Good	3
South Tyneside NHS Foundation Trust,	Excellent	4
Surrey and Sussex Healthcare NHS Trust,	Fair	2
Liverpool Heart and Chest Hospital NHS Trust,	Fair	2
The Rotherham NHS Foundation Trust,	Excellent	4
The Royal Marsden NHS Foundation Trust,	Excellent	4
Trafford Healthcare NHS Trust,	Good	3
	Good	3

University Hospitals Of Leicester NHS Trust,	Excellent	4
University Hospitals Of Morecambe Bay NHS Trust,	Good	3
West Suffolk Hospitals NHS Trust,	Excellent	4
Wirral University Teaching Hospital NHS Foundation Trust,	Good	3